REPORT OF THE
HEALTH SERVICES REVIEW COMMITTEE

VOLUME IV:
SUMMARY OF PUBLIC
RESPONSES TO THE REPORT

September, 1986

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September 15, 1986

The Honourable L. L. Desjardins
Minister of Health

Sir:

On behalf of the Committee members, I have the honour to submit the Summary of the Public Responses to the Report of the Health Services Review Committee.

Respectfully submitted,

David Pashoe
Chairman
Health Services Review Committee

HEALTH SERVICES REVIEW COMMITTEE MEMBERSHIP*

Lloyd C. Bartlett, M.D.	Manitoba Medical Association, Urban
Ted I. Bartman	Urban Non-Teaching Hospitals
Kenneth R. Brown, M.D.	College of Physicians and Surgeons of Manitoba
Don Carlow, M.D.	Urban Teaching Hospitals
Frank J. DeCock	Manitoba Health Services Commission
Clive Durham	Canadian Union of Public Employees
Irene Giesbrecht	Manitoba Organization of Nurses Associations
Eleanor Giffin	Manitoba Association of Registered Nurses
Brian I. Gudmundson, Recording Secretary	Manitoba Health Services Commission and Manitoba Health
John M. Horne, Ph.D.	Faculty of Medicine
Bryan W. Kirk, M.D.	Faculty of Medicine
Jack T. Litvack	Urban Teaching Hospitals
Sharon MacDonald, M.D.	Manitoba Health
John H. McBeath, M.B.	Manitoba Health Services Commission
David W. Pascoe, Chairman	Manitoba Health Services Commission and Manitoba Health
Peter Pauls	Rural Hospitals
Ted Redekop	Northern Health Services
Lawrence J. Stephen, M.D.	Manitoba Medical Association, Rural
Robyn M. Tamblyn**	Faculty of Nursing
John G. Wade, M.D.	Faculty of Medicine

* Individual contributions do not necessarily reflect the position of the sponsoring agencies or institutions.

** Robyn Tamblyn resigned from the St. Boniface General Hospital, Nursing Faculty, effective July 31, 1986.

HEALTH SERVICES REVIEW COMMITTEE
PUBLIC RESPONSES TO THE REPORT

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INTRODUCTION

The Health Services Review Committee was formed in December, 1983, with an invitation from the Minister of Health to individuals to participate. The letter of invitation, which appears as Appendix A, established a framework within which Committee members were requested to participate.

The Committee members are individuals who are representative of a variety of health care organizations including:

The College of Physicians and Surgeons of Manitoba;
Manitoba Association of Registered Nurses;
Manitoba Health;
Manitoba Health Services Commission;
Manitoba Medical Association, (Rural and Urban);
Rural Hospitals;
University of Manitoba (Faculty of Medicine);
Urban Non-Teaching Hospitals; and,
Urban Teaching Hospitals.

This broad constituency provided a balance between institutional and organizational forces and crossed the boundaries of educational, funding, and service concerns.

The first meeting of the Health Services Review Committee was convened in February, 1984. At subsequent meetings, the Committee refined its task to include four objectives. Thus, the terms of reference for the Health Services Review Committee were adopted by the Committee members as follows:

- To identify major cost areas and explore consolidation;
- To look for alternatives to in-patient services (e.g. more ambulatory care);
- To review current bed allocation and utilization; and,
- To review criteria of hospital admissions in both urban and rural hospitals.

The Committee created ad hoc committees to undertake specific topics of investigation. The topics were selected according to pressing issues of the day combined with those areas which presently consume a large majority of hospital days and medical services. The topic of mental illness was not included under the review of the Committee because this had previously been reviewed with a Report tabled with the Minister of Health entitled, "Mental Health Services In Manitoba, A Review and Recommendations", September, 1983.

The Committee commissioned fifteen sub-committees which reviewed the following areas:

Administrative Impacts;
Cardiovascular;
Continuing Care;
Critical Care;
Elderly;
Emergency;
Gastrointestinal;
Indian Health Services;
Not-For-Admission Surgery;
Obstetrics;
Oncology;
Out-Patient Medical Services;
Pediatrics;
Respiratory; and,
Terminal Illness.

The Committee recognized that several significant and interrelated changes are required for Manitoba's health care system. The scope of these changes is large. Any approach at piecemeal adjustments to the system was seen as an inadequate solution to cope with the demands of health care in the future.

The Committee emphasized that the health system needs to develop innovative alternatives of treatment and prevention to replace the present emphasis on in-patient services. Also, the Committee

emphasized that existing services should be continually monitored to ensure efficient utilization. Effective institutional admission and discharge committees, adequate ambulatory services and adequate community-based services are all necessary for the support of other interrelated components of the health care system. The Health Services Review Committee recognized that funding incentives would require change to provide appropriate emphasis for each of the various types of health care services.

The Health Services Review Committee endorsed a large number of recommendations presented by each of the fifteen sub-committees.

While several improvements in current services were supported by the Health Services Review Committee, the emphasis for change was on cost-effective alternatives to in-patient service expansion.

The Report of the Committee was received by the Minister of Health during November, 1985. In December, 1985, the Minister released copies of the Report and called for public response to the Report by June 30, 1986.

SUMMARY OF PUBLIC RESPONSES TO THE REPORT COMMITTEE OF THE HEALTH SERVICES REVIEW COMMITTEE

As of July 1, 1986 the Health Services Review Committee had received thirteen briefs in response to the Committee's Report. During July and August each brief was reviewed by the Committee to define topics of support and identify any concerns arising from the Report's recommendations. Following the Committee's review of each brief, a Committee response was sent to the author. Such replies noted that the key topics raised would be transmitted to the Minister of Health in this Summary Report.

The Health Services Review Committee observed strong endorsation for the general theme to expand diagnostic services and ambulatory services for the purpose of reducing demand on existing acute care facilities. Several briefs noted the current pressure on the existing health care system. Many briefs concurred that change in the health care system, as defined by the Committee, is needed promptly. The need for integration and coordination between health facilities and community health services was stressed by several respondents. Government commitment and consistency during the process of change was urged by some respondents.

Without exception, the major recommendations of the Health Services Review Committee Report were endorsed by the respondents. Additional supportive comments from several briefs included the following:

a) expansion of health promotion activities;
b) expansion of community health services;
c) development of improved health facility efficiencies; and,
d) development of an improved health information system (for comparative and timely health utilization data).

Many briefs expressed approval for the method of the review process undertaken by the Minister of Health. Additionally, many briefs complimented the Committee for a thorough examination of the

varied topics covered by the fifteen sub-committees. The general tone of the briefs was very complimentary, urging that the change process begin. From the briefs, the Committee observed that a consensus for the direction of change had emerged. The absence of strong objections in any of the briefs provided the Committee with encouragement that the change process could be successful.

The Committee reviewed thirteen briefs in response to the Health Services Review Committee Report. The briefs, in full, are listed as Appendix B. In summary fashion, the contents of these briefs are listed below:

1) Manitoba Medical Association:

The Manitoba Medical Association endorsed the general policy recommendations of the Report of the Health Services Review Committee. The Manitoba Medical Association asked for government commitment and consistency during the implementation process. Generally, a high level of support was offered for sub-committees' recommendations as well as recommendations of the Health Services Review Committee. Regarding the proposed consolidation of obstetric services and pediatric services, the Manitoba Medical Association noted objection. The Health Services Review Committee noted this concern and provided an amended recommendation on Page 12 (item #1) of this Report. The Manitoba Medical Association was very positive about the review process and the themes for suggested change. The Association urged review of any new ambulatory services to demonstrate effects upon the health care system. The Committee anticipates that short-term transitional funding may be required to facilitate the desired changes.

2) Manitoba Health Organizations Incorporated:

The Manitoba Health Organizations Incorporated provided a strong endorsation for the recommendations of the Health Services Review

Committee Report. They supported the concepts of expanded ambulatory care, improved coordination with community services and efficient use of existing facilities.

As future tasks, the Manitoba Health Organization recommended other topics of concern including:

a) development of rural "secondary health care centres";
b) exploration of the concept of case-mix groups; and,
c) evaluation of the proposed demonstration projects.

The Manitoba Health Organizations also requested involvement in the future review of health topics. Such participation was deemed to be appropriate by the Health Services Review Committee.

3) Manitoba Association of Registered Nurses:

The Manitoba Association of Registered Nurses broadly endorsed the Health Services Review Committee Report and the findings of its sub-committees. The Association urged that the change process begin for the health care system. To address expectations of several health care groups, the Association stressed the need for demonstration of change by Government. The Association urged future review of the topic of community health, not covered in the Continuing Care Sub-Committee Report.

4) Manitoba Organization of Nurses Associations:

The Manitoba Organization of Nurses Associations provided a broad endorsation of the Health Services Review Committee Report. The Association supported the theme of providing innovative alternatives for the health care system. The Association stressed that illness prevention and health promotion activities should be encouraged. The Association objected to the proposed further consolidation of obstetric services in Winnipeg. The Health Services Review Committee noted these concerns and provided an amended recommendation on page 12 (item #1) of this Report.

5) Manitoba Association of Licensed Practical Nurses:

The Manitoba Association of Licensed Practical Nurses provided general support for the Health Services Review Committee Report and findings of its sub-committees. The Association concurred with the Report's theme to expand ambulatory services. Specifically, the Association supported the concepts of increased public health education/health promotion, expanded community health services and expanded roles for personal care homes to provide rehabilitation services for their residents.

6) Manitoba Pre-Hospital Care Personnel Association:

The Manitoba Pre-Hospital Care Personnel Association provided a strong endorsation of the Emergency Health Care Sub-Committee Report. Specifically, the Association concurred with the proposed appointment of a provincial medical director for emergency services and encouraged preventive activities such as the Manitoba Alive Program. The Association also concurred with the proposed pre-hospital staff training levels for both Winnipeg and rural communities.

7) Health Sciences Centre Board:

The Board of the Health Sciences Centre commended the Health Services Review Committee for undertaking the "mammoth task" of such an in-depth study. The Board expressed appreciation for the opportunity to respond to the Health Services Review Committee Report. The Health Sciences Centre concurred with the emphasis to seek cost-effective provision for delivery of quality of health care on a regular basis. The Health Sciences Centre also concurred with the proposed strategy to develop innovative alternatives of treatment and prevention, contrasted with present emphasis on in-patient services. The Health Sciences Centre (as previously noted in the Health Services Review Committee Report) observed that the existing number of acute care beds in Winnipeg is adequate if additional ambulatory care and community support services are made available. The Health Sciences Centre

stressed that coordination between independent institutions and agencies would require a high priority. The Health Sciences Centre strongly endorsed the Committee's proposal for transitional funding to accomplish the proposed change for the health care system.

8) St. Boniface General Hospital Board:

St. Boniface General Hospital Board commended the Health Services Review Committee for completing its Report. The Board concurred with the Committee that the diagnostic services require expansion. The Board also concurred that improved efficiencies of in-patient facilities should be sought. The Board urged development of rural regional (secondary) acute care hospitals. The Board cautioned that further centralization of obstetric services in Winnipeg should not proceed. The Health Services Review Committee noted this concern and provided an amended recommendation on page 12 (item #1) of this Report.

9) Alcoholism Foundation of Manitoba:

The Alcoholism Foundation of Manitoba provided an assessment of the implications for their organization arising from the recommendations of the Health Services Review Committee Report. Identification of such implications were provided as information to the Committee. The Foundation's response requested that they be kept informed of the disposition of recommendations and be involved in future discussions which may provide improvement of the programs related to alcoholism treatment and prevention.

10) College of Physicians and Surgeons of Manitoba:

The College of Physicians and Surgeons of Manitoba indicated that they chose to provide no formal response to the Health Services Review Committee Report.

11) Dr. A. Cameron:

Dr. Cameron, Medical Director of the Rehabilitation Centre for Children, commended the Committee for giving strong emphasis to enhance pediatric rehabilitation programs within the province. He concurred

with the defined need for a more comprehensive data base to monitor service utilization. Dr. Cameron's comments focussed upon the recommendations of the Pediatrics Sub-Committee. He urged that existing and/or expanded ambulatory pediatric services be provided through the Rehabilitation Centre for Children. The Health Services Review Committee concurred with Dr. Cameron's suggestion that the Rehabilitation Centre for Children continue to provide a variety of ambulatory services and that appropriate provision for in-patient pediatric cases be ensured at the Children's Hospital, Health Sciences Centre. The Committee recommended that a new Sub-Committee regarding rehabilitation services be formed by October, 1986 and that Dr. Cameron be invited to participate in the review.

12) Dr. H. Greenberg:

Dr. Greenberg, member of the Gastrointestinal Sub-Committee, stressed the need for expanded ultrasound testing throughout Manitoba. He urged that ultrasound testing be allowed in physicians' offices. Despite noted problems with staffing recruitment and retention for ultrasound testing, Dr. Greenberg urged expansion of staffing to satisfy the increasing service demands and reduce waiting lists for routine ultrasound. Dr. Greenberg's concern for expanded staffing was referred to the Ultrasound Advisory Committee for further consideration.

13) Mr. L. Holgate:

Mr. Holgate, Executive Director of the Middlechurch Home of Winnipeg, provided personal comments to supplement the Manitoba Health Organizations' response to the Health Services Review Committee Report. Mr. Holgate urged that priority be given to develop the proposed Conjoint Planning Committee as defined in the Continuing Care Sub-Committee Report. Mr. Holgate also suggested that future topics for review should include the supply of health professionals and institutional long-term care. Mr. Holgate felt that the Manitoba Health Organizations could serve a useful role during future reviews by the Health Services Advisory Committee.

Administrative Impacts Sub-Committee Report:

The Administrative Impacts Sub-Committee (see Appendix C) attempted to define re-occurring themes of other Sub-Committees and define significant principles to facilitate the change process recommended by the Health Services Review Committee. The Sub-Committee defined several factors necessary to facilitate the desired change. The Sub-Committee chose to avoid any prescriptive approach which would apply specific constraints upon individual health facilities. The Sub-Committee recommended that a task force be established to review and recommend a number of models which could be established to provide a more effective approach to health care funding and financial management within health care facilities.

The Sub-Committee also recommended that a health care management training course be developed in Manitoba for health facility directors and other area managers to serve administrative demands. The Sub-Committee concurred that demonstration projects for innovative administrative structures and practices in health care facilities should be promoted. The Sub-Committee recommended that performance appraisal procedures should be developed for senior health care administrators to ensure that sound objectives for health facilities are being achieved. The Sub-Committee also urged that Manitoba's health information system be improved to provide timely, accurate and comparable data for Manitoba's health facilities. The proposed Conjoint Planning Committee (defined by the Continuing Care Sub-Committee) was strongly endorsed by the Administrative Impacts Sub-Committee. The Sub-Committee also recommended that membership for provincial advisory committees should include representation from other service areas such as community hospitals.

To begin the process of administrative change, the Sub-Committee recommended that a series of regional meetings, sponsored by the Manitoba Health Organizations, be undertaken to share the findings of the Health Services Review Committee with health providers and solicit

comment for administrative innovations appropriate to individual facilities. The Sub-Committee supported many of the other Sub-Committee Reports which concurred with the emphasis of the Health Services Review Committee. Three themes from the other sub-committees' recommendations emerged during the Administrative Impacts Sub-Committee's discussions including the following:

a) Mechanisms for reduction of waiting time for diagnostic services should be introduced to reduce demands on hospital beds.

b) Rural regional centres should be promoted where possible and encouragement of itinerant rural diagnostic services should be promoted.

c) A future discussion forum (provided by the Manitoba Health Organizations) should be established to include the participation of health providers and government in the process of change for health services in Manitoba.

Health Services Review Committee Comments:

The Health Services Review Committee concurred with the major themes of the Administrative Impacts Sub-Committee, noting the macro approach to the administrative issues. Without specific recommendations affecting individual facilities, the Committee observed that several tasks, such as defining fiscal incentives, remain.

The Committee agreed that the change process should be started with the Fall meetings supported by the Manitoba Health Organizations, Inc. It was felt that continued collaboration with a mix of health professionals and trustees would develop the emerging consensus for change.

Outstanding Issues

1) Obstetrics Service Consolidation:

Three briefs received by the Health Services Review Committee cautioned that further consolidation of obstetric services in Winnipeg should not occur. The previous recommendation of the Health Services Review Committee was for three obstetrics units in Winnipeg, two teaching hospitals and one community hospital (unspecified). The Committee examined summary data about live births in Manitoba which indicated a recent increase in the number of births in Winnipeg hospitals. The Committee noted that the previous assumption of low inter-provincial migration appeared incorrect, causing a proportional increase in the number of births in Winnipeg.

Given this additional information and the responses noted above, the Committee felt that no decision should be taken at this time. However, the Committee recommends that the Obstetrical Sub-Committee be reconstituted to reconsider the proposed further consolidation of obstetrical services in Winnipeg and provide advice regarding the organization of obstetrical services in rural Manitoba up to 1991.

2) Pediatric Service Consolidation:

Two briefs cautioned that consolidation of pediatric services was not desirable. The Committee reiterated its proposed consolidation for in-patient pediatric services. The Committee's rationale was that only severely acute pediatric cases should be treated as in-patients. A corresponding increase in the number of ambulatory pediatric services would be required to correspond with this intent.

3) Dedicated In-patient Beds for the Terminally Ill:

No public consensus emerged regarding the topic of providing dedicated beds within health facilities for the terminally ill as indicated in the briefs outlined on pages 5 to 9. The Committee supports the concept of dedicated beds, but cautioned that establishment of dedicated beds should not disrupt or curtail the patient's relationship with his/her family practitioner (ie., open admission policies).

Conclusion:

Following the Minister's release of the Health Services Review Committee Report in December, 1985 the public had the opportunity to review and comment upon the full Report of the Health Services Review Committee. During July and August, 1986 a total of thirteen formal briefs were received by the Committee, commenting upon the Committee's Report and the Sub-Committees' Reports. Following review of the thirteen formal briefs, the Committee observed a repeated strong endorsation of the manner of change recommended in the original Report of the Health Services Review Committee. The individual briefs, once compiled, began to demonstrate a pattern of consensus in Manitoba for both the goals of health care change and the necessary means to facilitate such change. This Summary Report concludes the work of the Health Services Review Committee as mandated by the Minister of Health in his request for review of the public responses.

APPENDICES

APPENDIX A

MANITOBA

MINISTER OF HEALTH
MINISTRE DE LA SANTÉ

WINNIPEG, MANITOBA
R3C 3H8

FEB 3 1984

Dear

I have requested David Pascoe, Director of the Research and Planning Directorate, to chair a Health Services Review Committee. The Review Committee will be established in February, 1984, to examine several critical health issues during the following five months. I ask that your institution participate in this important effort by appointing Mr. Gerry Hiebert.

The Review Committee will be comprised of approximately fifteen members from urban hospitals, rural hospitals, the College of Physicians and Surgeons, the University of Manitoba, the Manitoba Medical Association, the Manitoba Association of Registered Nurses, and senior government staff. The Review Committee is intended to function as a steering committee, striking sub-committees with expanded membership to review selected topics.

The terms of reference for the Review Committee are to examine current health issues and recommend future directions to the Minister of Health. Specific issues for review have not been defined for the Committee. The Committee will establish its own agenda. Examples of key topics include:

(a) hospital bed supply;
(b) ophthalmology services; and,
(c) alternatives to hospital admission.

... 2

This listing is not intended to be exhaustive.

It is intended that members of the Review Committee meet twice per month. I have requested the Manitoba Health Services Commission to reimburse committee members for travel costs and other out-of-pocket expenses. I trust that sponsoring agencies will provide sessional fees for Review Committee members where necessary.

The suggested afternoon meeting schedule in the M.H.S.C. executive boardroom is as follows:

February 20
March 5, 19
April 2, 16
May 7, 22
June 4, 18

The secretarial/support services will be provided by the Research and Planning Directorate. If you have any questions, please contact the Chairman of the Review Committee, David Pascoe, at 772-7702; 206 - 1580 Dublin Avenue, Winnipeg, R3E 0L4.

Please notify Mr. Pascoe of your decision to participate on the Review Committee. I wish to thank you in advance for your anticipated co-operation.

Yours sincerely,

ORIGINAL SIGNED BY
L. L. DESJARDINS

L. L. Desjardins

APPENDIX B

June 30, 1986
Our Ref: 21

Hon. L. L. Desjardins
Minister of Health
7th Floor - 175 Hargrave Street
WINNIPEG, Manitoba
R3C 3R8

Dear Mr. Desjardins:

I am pleased to enclose the Association's official response to the Report of the Health Services Review Committee.

On behalf of the Board of Directors, I wish to take this opportunity to again recognise the invaluable contributions of Dr. L. C. Bartlett and Dr. L. J. Stephen, who served on the Committee and assisted greatly in the Board's deliberations.

I look forward to discussing the Report and our response with you during the coming months.

Sincerely,

J. R. SUTHERLAND, M.D.
President

JRS/kv

cc: Mr. D. Pascoe

COPY

MANITOBA MEDICAL ASSOCIATION

RESPONSE TO

REPORT OF THE

HEALTH SERVICES REVIEW COMMITTEE

JUNE, 1986

The Manitoba Medical Association endorses the primary thrust and general policy recommendations contained in the three-volume Report of the Health Services Review Committee. We believe that Manitoba physicians will take up the challenge to help "develop innovative alternatives of treatment and prevention to replace the present emphasis on in-patient services."

Such a fundamental shift in the health care system's deep-rooted structure will require three essential elements: commitment, time and increased funding, at least during the transitional phase.

The degree to which the medical profession welcomes and co-operates with a new focus on community-based health care will hinge on government's commitment and consistency in this area. If doctors and other health care professionals are to redirect their work effort onto the same course, funding priorities must identify community-based care as the guiding principle. A blend of both consolidation and community-based care as the Report sometimes implies would lead to troublesome inconsistencies in practical terms.

More decentralized care is at the heart of the Report's broad recommendations vis-a-vis "effective institutional admission and discharge committees, adequate ambulatory services and adequate community-based services...funding incentives...to provide appropriate emphasis for each of the various types of health care service."

Consumers and providers of health services would have to change their expectations, if not lower them, and this gradual educational process should be expected to take several years. An ambitious program of rapid change would alienate doctors and their patients.

During this phase Manitoba Health must be willing to increase expenditures, at least in the short term, since established institutional services cannot be reduced until viable community-based alternatives are in place and working satisfactorily.

General comments and concerns

o The Association's review of the Report generally focused on Volumes I and II. We assume that the detailed recommendations in Volume III will be further discussed by the Health Services Review Committee before implementation is contemplated. Our nominees on the Committee will provide additional feedback on these numerous recommendations during this process.

o The value of good primary medical care is likely to be reinforced under a community-based system. Sensible and sensitive primary care draws its strength from a direct patient-doctor relationship. This relationship often is enhanced by a multi-disciplinary health care approach, but the physician must retain ultimate responsibility for a patient's treatment. This ensures appropriate referral to specialized services, be they medical, institutional or provided in the community.

o We agree that "efficiencies of existing services should be continually monitored to ensure proper utilization" as stressed in the Report. We hasten to add, however, that all aspects of the health care system should be monitored to guage effectiveness as well as quality assurance. This would include all new, community-based services, administration at all levels and all health care workers.

o A well-coordinated plan of both existing and prospective health services must be developed to avoid unnecessary duplication. Competition among Winnipeg hospitals must be discouraged, particularly between the tertiary centres.

o A team approach in planning, implementation, monitoring and revision of new services is vital. Personal interest and morale are maintained at peak levels in this manner. Physicians and allied health workers must be a part of this administrative team.

o The Faculty of Medicine at the University of Manitoba would have to adapt the medical curriculum to meet a shift in priorities. Community-based medical care would require special emphasis by the medical school. Continuing medical education programs should be tailored accordingly.

o Moving away from institutional care would alter dramatically longstanding patterns of medical practice. Anticipated cost savings in hospitals would be partially offset by increased physician billings to MHSC. The Medical Review Committee, among others, must be able to develop new methods of peer review to accommodate what would be a more expensive pattern of medical practice. The MHSC must acquire the flexibility to provide meaningful incentives to physicians to concentrate their skills in the community.

o The Government would be well-advised to reflect long and hard on the likelihood of expected cost savings. A long-term funding commitment is essential to broaden and maintain community resources.

o The Association is eager to co-operate with Government in public education aimed at preventable disease, most especially illness caused by smoking and other lifestyle hazards.

Subcommittee on Administrative Impacts

We agree with the Report's conclusion that "existing structures for dialogue, information sharing and coordination of health care services (are) inadequate." In March, 1986 the Association nominated Dr. F. D. Baragar for appointment to this subcommittee, whose real work now begins. We request a response in respect of this nomination.

Subcommittee on Cardiovascular Disorders

Key findings:

1. Expansion of ambulatory facilities for diagnostic testing;
2. Expansion of N.F.A. surgery and preadmission clinics to reduce demand on acute beds;
3. Stress testing to be provided outside hospitals;
4. Education measures to be undertaken to advise the public of conditions leading towards atherosclerotic heart disease;
5. Pediatric cardiology specialists to provide consultation in rural regions to assist with proper referrals to Winnipeg acute beds;
6. Utilization of trained nurse clinicians; funding may be possible through hospitals' trade offs within existing global budgets.

MMA position:

1. Supported.
2. Supported.
3. Supported, assuming a physician is on hand (not just on call) and defribrillation equipment is in place. Standards must be followed closely.
4. Supported.
5. No support. In our view, it should be less costly overall to transport selected patients to a tertiary centre assuming only appropriate referrals are made. This would maximize the cardiologist's time by only dealing with prediagnosed problems.
6. Supported, with the understanding that specially-trained nurses work under a physician's general supervision. We have some misgivings about the suggested manner of funding these nurse clinician positions.

Subcommittee on Continuing Care

Key findings:

1. Establishment of a conjoint planning committee;
2. Emphasis on the importance of enhanced information exchange and working relations between institutions and community health service workers;
3. Need for convalescent beds and long-term hospital beds for the care of persons requiring very heavy or specialized care;
4. Recognition that the health service network in Manitoba is an integration between institutional, medical and community services; when one component is arbitrarily impeded, for example by staffing restrictions, the pressure is then transferred to the other components of service.

MMA position:

1. Supported. The Association wishes to be represented on this conjoint planning committee.
2. Supported. This cannot be over-emphasized.
3. Supported.
4. Supported. Community care must be available on a 24-hour basis as are institutional and medical care.

Subcommittee on Critical Care

Key findings:

1. Existing physician shortages should be eliminated with increased training of intensive care nurses;
2. Intermediary care beds should be developed (from the existing bed supply) to serve as step-down beds between the critical care units and standard ward care;
3. Professional associations should develop standard qualifications for both medical and nursing personnel to serve in critical care units;
4. The Report of the College of Physicians and Surgeons of Manitoba on transportation and northern medical services should be implemented by the Manitoba Health Services Commission.

MMA position:

We endorse all of these recommendations noting that physician supervision of I.C.U. nurses is required. More specially-trained nurses will ameliorate, but not eliminate, existing physician shortages.

Subcommittee on Health Services for the Elderly

Key findings:

1. Provide "supported independence" to keep the elderly out of institutional settings by providing adequate supports in the community;
2. An expanded array of ambulatory services and institutional services to appropriately respond to the needs of the elderly;
3. Utilize geriatric assessment and consultation to guide subsequent management of treatment and reduce inappropriate use of institutional services;
4. Improve organizational control through a single departmental structure.

MMA position:

We welcome and concur with the first three recommendations. We are opposed to the establishment of a single departmental structure. From a philosophical standpoint, the creation of yet another government bureaucracy is worrisome. On practical grounds, care of the elderly should be integrated with all other community health services and not regimented under one department. A real need exists to coordinate care for the chronically disabled, of which the elderly comprise a significant portion, but this coordination should be based on specific needs, not on a person's age.

Subcommittee on Emergency Health Care

Key findings:

1. Each hospital should have an active bed utilization committee responsible for admission and discharge planning;
2. Alternative placement of chronic care patients as a priority for discharge;
3. Expand emergency services in remote/rural communities; these should meet uniform standards;
4. Appoint a medical director of provincial emergency services to establish guidelines for the level of training of physicians, nurses and prehospital care personnel;
5. Health promotion to minimize demands upon acute hospital services.

MMA position:

We endorse all of these broad recommendations. In volume three, however, we do not support the recommendation that advanced ATLS training should be provided to emergency nurses although ACLS training is strongly supported. Similarly, we agree that all rural hospitals should have ambulance personnel trained at the CMA I level as the minimum standard, but this should not be limited to hospitals with 60+ beds.

Subcommittee on Gastrointestinal Disorders

Key findings:

1. Expansion of diagnostic procedures for early detection and treatment;
2. Expansion of facilities for N.F.A. surgery;
3. Develop "mini regions" to allow concentration of diagnostic and therapeutic equipment while preventing costly duplication of inadequate facilities.

MMA position:

Expanded facilities for N.F.A. surgery would be welcomed, but not at the expense of reducing diagnostic in-patient facilities. All other recommendations generally are supported.

Subcommittee on Indian Health Care

Key findings:

1. Indians must be involved in, and have control of, health care delivery in Indian communities;
2. Recognition of the provincial government's role as a partner in the provision of health services to Indians;
3. A tripartite mechanism to make decisions at the most senior level regarding the federal government, the provincial government and the Indian Community.

MMA position:

We endorse all of these recommendations.

Subcommittee on N.F.A. Surgery

Key findings:

1. Concluded that there were numerous possibilities to expand N.F.A. surgery on cases that are currently treated on an in-patient basis;
2. In order to support this transfer, recommended the systematic development of N.F.A. surgical programs with the proviso that concurrent with this was the development and implementation of:

   - preadmission evaluation, instruction and preparation of the patient;
   - preoperative anesthesia assessment;
   - a postoperative recovery room and observation area with dedicated staff, and;
   - provision for postoperative follow-up including home nursing visits.

MMA position:

We support all of this report.

Subcommittee on Obstetrics

Key findings:

1. A city-wide expansion of pilot projects like those established at St. Boniface General Hospital. These projects include a postpartum early discharge program and an antepartum nurse visiting service.
2. Expansion of perinatal units at Health Sciences Centre and St. Boniface General Hospital such that a process of gradual consolidation can be adopted.
3. A training course for neonatal nurse clinicians recognizing the difficulty in retaining neonatologists.

MMA position:

Recommendations 1 and 3 are supported. The second recommendation is incompatible with the Report's main thrust of decentralization. Likewise it runs afoul of a long-standing MMA policy (see Appendix 1) in support of community-based obstetrics.

Of yet greater concern, the further consolidation of obstetrics would hurt the practice of family medicine and alienate many physicians at a time when their active support of community-based care is most needed.

We do not accept the notion that centralized obstetrics necessarily leads to improved patient care. If this assertion is true, then Manitobans ultimately will be getting a two-tiered system: care in a tertiary setting for Winnipeggers and those who live nearby; primary care for all others, who, because of geography, will never get into a tertiary centre. This double standard is unacceptable.

To encourage women to deliver their babies in a few high-technology, high-cost centres means that more women will deliver en route to hospital.

We recognize that Government must choose between two positions which are opposed diametrically. Consequently, we are willing to mediate between family physicians and obstetricians in this regard such that a compromise may be forged.

Subcommittee on Oncology

Key findings:

1. Expansion of prevention activities such as workplace safety monitoring, anti-smoking advertising, and continued screening for breast cancer.
2. Expand ambulatory services and dedicate 40 acute beds for oncology use.
3. Provide resources for care in the home for terminal pediatric cases.
4. Establish a central registry for oncology patients.

MMA position:

We concur with these recommendations.

Subcommittee on Out-Patients

Key findings:

1. Expansion of diagnostic and therapeutic services which currently require admission to hospital (dialysis, chemotherapy, out-patient intravenous antibiotics, ambulatory Total Parenteral Nutrition and high-risk prenatal care).

2. Expanded ambulatory services for the elderly.
3. New cost-sharing arrangements for out-patient services in teaching hospitals are required.

MMA position:

Increasing the emphasis on out-patient care is best accomplished by reinforcing established hospital out-patient programs and developing new programs which permit close co-operation with doctors in primary care. Appropriate administrative arrangements should be negotiated in this regard. In this way continuity of care is preserved and potential cost savings may be realized.

A good out-patient program is not free-standing. It receives patients at the request of the primary physician in the first instance, provides appropriate treatment in consultation with the doctor, and returns the patient to the doctor for ongoing management.

Manitoba physicians, for the most part, have had a favorable experience with out-patient programs for the management of diabetes, hypertension, heart disease and cancer. The Association has and will continue to support programs which integrate physicians in this manner. We have been assured by the Chairman of the Health Services Review Committee that expansion of "community clinics" is not recommended, therefore we support the central theme of the out-patient report (see Appendix 2).

The subcommittee appears to have concentrated much of its review on fiscal arrangements between the teaching hospitals and geographic full-time physicians. This is a complex matter which rightly should be sorted out between the two parties involved.

Subcommittee on Pediatrics

Key findings:

1. Consolidation of pediatric services at the Children's Centre and the St. Boniface General Hospital.
2. Expand preventive services and increase ambulatory care facilities.
3. Consolidate neonatal and pediatric intensive care within one facility, the Children's Centre.
4. Train neonatal nurse clinicians.
5. Urgent need for pediatric rehabilitation services (physiotherapy, occupational therapy and speech therapy).

MMA position:

Recommendations 2 and 5 are supported. The fourth recommendation is acceptable provided nurse clinicians work under the supervision of physician neonatologists.

The Association opposes the consolidation of pediatric services as proposed if for no other reason than the risk of an epidemic effectively blocking new admissions. This would place a tremendous burden on the other tertiary centre which, itself, could be quarantined.

Subcommittee on Respiratory Disorders

Key findings:

1. Patient ventilation should be authorized for use in personal care homes.
2. Expand home care staffing to reduce caseloads and permit improved monitoring of home care clients.
3. Construct additional extended treatment hospital beds to free up existing acute care beds.

MMA position:

We support these recommendations. However, the Association is disappointed that this subcommittee did not propose aggressive preventive and educational measures against smoking. This, more than anything else, would be the most effective way to deal with most respiratory disorders.

Subcommittee on the Terminally Ill

Key findings:

1. Involve the College of Physicians and Surgeons to establish clarification regarding the management of terminal illness.
2. Refer to the Manitoba Health Organizations the issue of patient autonomy and rights to information.
3. Organization of services in dedicated units.

MMA position:

We accept the first two recommendations. We believe physicians have a major role to play in defining patient autonomy and rights, therefore we want to work closely with MHO in this matter.

Provided that terminally ill units were optional for the patient and were accessible by primary care physicians, the Association could support the third proposal.

MMA
Winnipeg, Manitoba
June 30, 1986

M.M.A. APPENDIX 1 - A

2 June 1983

Our File: 42

Hon. L. L. Desjardins
Minister of Health
Legislative Building
Winnipeg, Manitoba
R3C 3R8

Dear Mr. Desjardins:

Your 27 May 1983 letter to my predecessor, Dr. Kowalchuk, refers.

The statistical information upon which government has based its decision to close the obstetrical units of the Seven Oaks and Concordia Hospitals appears logical at face value. But there is a "human" dimension to this issue which we believe has not been fully explored.

Many patients do better in the intimate atmosphere of a community hospital as opposed to being "just another patient" in a mammoth institution. The loss of obstetrical services also adversely impacts the provision of paediatric services in the community, another severe blow to the "human" dimension.

The enclosed letter describes the real concerns of most physicians throughout the province. Our 28 May 1983 Annual General Business Meeting strongly endorsed the Board's position, namely:

> "THAT the Manitoba Medical Association supports the concept of community hospital obstetrics, as opposed to centralized hospital obstetrics, in continued support of community-based medical care."

Since no decision has been taken with respect to the exact timing of these closures, we request the opportunity to meet with you on an urgent basis to discuss the "human" aspects.

Yours sincerely,

NEIL HEYWOOD, M.B., Ch.B.
President.

NH/sgp
Enclosure
bcc: Dr. A. Valentine
Dr. H. T. Dirks
Dr. W. Gaman
Dr. O. Domke

MISERICORDIA GENERAL HOSPITAL
99 CORNISH AVENUE — WINNIPEG, MANITOBA
R3C 1A2

FROM
MEDICAL STAFF

(204) 774-6581

May 20, 1983.

RECEIVED
MAY 25 1983
MANITOBA MEDICAL ASSOCIATION

Dr. I. Kowalchuk, President,
Manitoba Medical Association,
125 Sherbrook Street,
Winnipeg, Manitoba, R3C 2B5

Dear Dr. Kowalchuk:

Re: Obstetrics and Pediatrics Units in Community Hospitals

The Department of Family Practice of the Misericordia Hospital, consisting of 67 members, passed a resolution at a recent meeting concerning the above-mentioned subject.

The Department feels strongly that obstetric units in community hospitals should be maintained and strengthened. The reasons for this include the fact that the units at both the Health Sciences Centre and the St. Boniface Hospital are becoming overcrowded. Also, many patients would prefer to have their deliveries in the smaller, more intimate atmospheres of the community hospitals, where they are attended by their own physicians whom they know well. Finally, the fact that if family physicians are to continue to do obstetrics, it is most important that they do them in hospitals where they can retain their skills instead of being somewhat overwhelmed by a large number of residents, internes and students.

Arising from the potential loss of obstetric departments in community hospitals, there is the possibility that departments of pediatrics will be attenuated and the hospitals will lose pediatricians and also skilled nursing staff.

To sum up, the Department of Family Practice of the Misericordia Hospital is very much against obstetric and pediatric departments being, in any way, weakened for the above-mentioned reasons.

Yours sincerely,

A. Valentine, M.B., B.Chir., F.C.F.P.
Head,
Department of Family Practice.

/pc

30

Manitoba

M.M.A. APPENDIX 2

Health

Health Services Commission
Research and Planning

308 Somerset Place
294 Portage Avenue
Winnipeg, Manitoba, CANADA
R3C 0B9

(204) 945-8699

January 29. 1986

Mr. John Laplume
Executive Director
Manitoba Medical Association
125 Sherbrook Street
Winnipeg, Manitoba
R3C 2B5

Dear Mr. Laplume:

I am writing with regard to your request for additional information regarding the Health Services Review Committee Report and any implication that the Report might have on the development of community clinics.

The focus of the recommendations put forth for consideration by the Health Services Review Committee did not include a recommendation to expand community clinics.

The Health Service Review Committee recommended for consideration the systematic development of ambulatory care facilities. This would encompass both the ambulatory care medical work as well as the not-for-admission surgical procedures. This is in keeping with two sub-committee reports one chaired by Dr. L. Bartlett on not-for-admission surgery and another chaired by Dr. C. Murphy on out-patient medical clinics. The focus of the Health Services Review Committee thus revolved around the possibility of developing ambulatory care settings and did not refer to the development of, or expansion to, community clinics as they are currently known.

I trust that this provides you with the clarification that you requested. Should you need additional information I would be pleased to provide it to you in writing or to attend any meeting that you might wish to convene with your Board members.

Yours truly,

David Pascoe
Chairman
Health Services Review Committee

DP/ls

MANITOBA HEALTH ORGANIZATIONS INCORPORATED
•600-380 BROADWAY WINNIPEG, MANITOBA R3C 4G6 - TELEPHONE (204)942-6591

June 30, 1986

Mr. David Pascoe
Health Services Review Committee
308 - 294 Portage Avenue
Winnipeg, Manitoba
R3C 0B9

Dear Mr. Pascoe:

The Manitoba Health Organizations Inc. (MHO) wishes to record its appreciation for the opportunity to participate in the review and analysis of the current system of health care delivery in the province. The analysis which MHO is presenting is the result of input from selected representatives of our acute and long term care membership, both trustees and administrators.

We regret that a planning project of this magnitude and importance was conducted without formal input from MHO. Our membership have been aware of the issues and financial constraints surrounding the province's health care system for some time and on its own initiative have been taking steps to address them. This has resulted in unique examples of shared services and, under the umbrella of the District Health and Social Services Act, demonstrations of effective cost containment. Accordingly, the organization through its staff and membership, is uniquely qualified to contribute to a review of the province's health care system. Our attached Mission Statement, Aims & Objectives describe more fully our position in the province's health system.

Notwithstanding, MHO believes that there are many issues which have been identified in the Health Services Review Committee report which deserve discussion and many which should be implemented. Once the Health Services Review Committee has had the opportunity to review MHO's response, we hope to be able to examine these issues with you in greather depth.

Sincerely,

Henry Neufeld
Chairman of the Board

Encl.

cc: The Honourable L.L. Desjardins
Minister of Health

Jeffrey C. Lozon
Executive Director, MHO

MANITOBA HEALTH ORGANIZATIONS INC.

RESPONSE

TO

REPORT OF THE HEALTH SERVICES REVIEW COMMITTEE

A Report of the
Policy Advisory Committee on
Health Care Systems

June 30, 1986

June 30, 1986

REPORT
HEALTH SERVICES REVIEW

The Manitoba Health Organizations Inc. (MHO) wishes to record its appreciation for the opportunity to participate in reviewing the Report of the Health Services Review Committee.

Our membership have been aware of the issues and financial constraints surrounding the province's health care system for some time and support the intent of the review and its general results. Please see appendix for synopsis of our views on the sub-committees' recommendations.

The comments that follow are based on analysis done by selected representatives of our acute and long term care membership, both trustees and administrators. Their objectives included:

1. Relating the report's findings to trends already appearing in parts of the province.
2. Assisting the government in taking a broad overview of the province's health care system.
3. Demonstrating MHO's willingness to provide leadership to its membership in cost containment while enhancing quality and maintaining Board autonomy.
4. Contributing to an important process.

To begin, it is important to be explicit on certain basic principles:

Our membership supports initiatives to contain costs. We reaffirm, however, the need for facilities to develop their own methods of cost containment to reflect the unique needs of each local district. This evolution could and should result in consideration of alternate delivery systems: whether they be innovative new programs or rationalizing resource use between adjacent facilities. MHO recognizes that this could result in centralization of certain health services around focal points in rural Manitoba.

We also wish to point out that efforts to contain costs must be considered only as an integral process of maintaining or enhancing the current quality of care. This can be achieved through participative planning, involving and actively using the diverse expertise of the province's trustees and administrators. Indeed, the role of autonomous health care boards is a necessary ingredient to this process as they must undertake to establish on-going methods of program/service evaluation.

We believe that alternate delivery systems should focus on ambulatory and community support services and include aspects of health promotion and prevention. To this end, MHO supports increased public health education and increased emphasis on community and primary health care issues in the education of health professionals.

The lack of coordination/integration of the wide variety of health services is of concern. We suggest that our health system will only be effective when a consumer can enter the system at any access point and receive the full continuum of care appropriate to his needs, without interruption.

In keeping with the above principles, certain of the Report's important issues will be discussed to review their application to our current health care system.

1. Current Experience

Cost savings can be achieved by means of increased organizational efficiency and effectiveness. Larger issues of shared services however must be addressed. We would point out that experience in parts of rural Manitoba demonstrate that shared services between adjacent communities have evolved through recognition of common need and through cooperative and joint long term planning.

The result has been voluntary formal and informal groupings of small rural facilities demonstrating responsive and responsible reactions to local health care needs and financial constraints. These "regional" groupings of three or four facilities demonstrate coordinated approaches to service delivery where individual facilities did not have the resources/expertise to deliver care. Three approaches are seen, namely:

1) Voluntary conjoint establishment of an incorporated umbrella board responsible for planning, coordination of medical manpower, banking, group purchasing, and the sharing of computerized financial management and administrative support for separately incorporated facilities. BGTW Inc., (Baldur, Glenboro, Treherne, Wawanesa), which has adopted this approach, is exploring the feasibility of dedicating each facility to a different clinical specialty.

2) Inter-facility sharing of limited expertise, developed as a cooperative venture between adjacent facilities, for example, Tri-Lake, Boissevain and Souris.

3) Multi-facility organizations incorporated under one board using the District Health and Social Services Act and showing varying degrees of aggregation of the facilities' budgets, for example, Red River Health District, Lakeshore Health District.

We recognize that not all models are equally effective and that they are more applicable in rural than urban situations. We note and re-emphasize that these developments have been voluntary and board-initiated.

In rural Manitoba, true local primary care centres are evolving, which offer a range of curative and preventive health care services

with a small number of back-up emergency beds. Some rural hospitals and PCH's see themselves as appropriate convalescent sites for local residents who are treated in urban secondary and tertiary centres.

A further level of coordination is evidenced between facilities represented on the Westman Council for Services to the Elderly. This regional coordinating committee, composed of voluntary representatives from different facilities (trustees and administrators), ensures equitable and integrated delivery of long term care services.

At the same time, secondary care sites in different parts of the province are delivering some services which are similar to those provided in urban community hospitals. This development must be encouraged because the future viability of evolving primary care centres will depend on the effectiveness and location of these secondary regional centres.

2. Ambulatory Care

The report describes the need for a wide range of ambulatory diagnostic and therapeutic services. It recommends the establishment of ambulatory care departments in the large facilities to increase accountability, control and effectiveness. MHO supports this and would suggest that this direction is appropriate in both urban and rural Manitoba. MHO also supports the interim decision to allocate increased funding to ambulatory and community based programs.

It is important to ensure that the quality of ambulatory care services are equivalent to in-patient care services. Further, it is imperative that steps are taken to ensure that beds released by increasing ambulatory services are appropriately used for other patients.

MHO supports the development of out-patient programs to increase the cost-effectiveness of in-patient services.

Coordination of out-patient and community services will become increasingly necessary to provide adequate home support. Recent literature describes the effectiveness of a hospital-based home health agency in Pennsylvania, U.S.A. in assuring continuity of care.

Financial advantages in cost avoidance and containment will not be immediately apparent. The transition in moving from a predominatly in-patient service to an ambulatory one will require additional temporary funding to prevent gaps in current programming. It must be recognized that benefits will accrue over time.

3. Primary Health Care and Prevention

MHO supports the recommended shift to increasing primary and preventive health care activities. Certain of our rural membership are already redefining their role by providing curative and preventive care, for example, Dauphin General Hospital through their CPR and stroke public education programs and Seven Regions Health Centre through their outreach programs. This dual role is not seen as frequently in urban hospitals and needs to be encouraged through funding incentives.

Staffing advantages are also to be gained by developing primary care centres. In rural Manitoba where there is a chronic shortage of physicians, medical manpower needs could be satisfied to some extent by training and using nurse practitioners as primary health care workers. In urban Manitoba, nurse practitioners could contribute to increased multi-disciplinary needs assessment to reduce the reported incidence of inappropriate admissions, particulary among the

geriatric population. We strongly urge the establishment of educational programs for training nurse practitioners.

The role of physicians is vital, not only at the direct level of care, but in the planning and development of appropriate programs and services. This view of physician utilization is being applied by Winnipeg's Victoria Health Guard Inc. in its occupational and environmental health care programs.

Itinerant specialists, through the Northern Medical Unit, have been used at the Churchill Health Centre to enhance the quality of services. This concept, when extended to the services of general practitioners, can satisfy many of the primary health care needs of under-serviced areas and has proven to be effective in certain multi-facility organizations. MHO would support its wider application.

4. Monitoring and Communications Systems

MHO's membership has long recognized the need for sound patient, financial and management information systems and has demonstrated the effectiveness of automating such systems. On-going development and/or enhancements are being pursued. MHO's long term care members have initiated the development of an automated information system to improve their ability to monitor patient mix and care delivery.

Developments in long term care in Manitoba are progressive when compared to the national scene; the converse applies to developments in the province's acute care sector. In the USA, funding is being based on disease related groups to project and contain costs. In Ontario, the concept is being "Canadianized" into case mix groups. To MHO's knowledge, this method of using patient information is not being pursued in Manitoba. We would support local investigation

into the applicability of case mix groups, the expanded use of standardized indicators and improvements in communicating comparative statistics to facility boards for use in their planning and day-to-day operations.

The potential for savings and improved health care delivery through increased use of communications technology need to be aggressively explored and we commend existing projects (psychiatric consulting, diagnostic ultrasound and EKG). However, MHO suggests that more pilot projects are needed to determine whether other cost savings exist and to assess their diagnostic and treatment capabilities.

5. Northern Health Care

MHO subscribes to the philosophy of local control of health care. The principle of community health care boards made up of volunteers is also applicable to the native populations in the north. To make this workable, however, a single funding agency must be identified and opportunities created for natives to be oriented to the role of health care boards. The Churchill Health Centre, although funded by different agencies, provides an appropriate model demonstrating the effectiveness of community input into decision-making.

6. Long Term Care

It is important that a wider role be considered for PCH's as long term care centres and not exclusively as geriatric residences. The present and future roles must be the subject of public education to ensure appropriate use of services such as respite beds.

Initial contact with the long term care system should be with the major objective of rehabilitation and return to the community. Residents should be admitted to a long term care bed as part of a

continuum of care initiated by intensive multi-disciplinary assessment, whether occurring in the community or in the geriatric assessment unit of a hospital. Permanent placement should be considered only after all other efforts have been exhausted to retain the client in his home environment.

This approach would require that there not only be adequate tertiary level assessment centres (as is being developed at Deer Lodge) but also assessment centres in designated secondary sites in the province, useful for initial intake purposes as well as back-up support for crisis intervention.

The range of services in such long term care centres could include ambulatory care, outreach, pastoral care, respite care, adult day care, psychiatric services, family counselling, palliative care and convalescent care, for example, oxygen therapy. Outreach services could include the use of itinerant geriatric or long term care specialist staff who would provide offsite programs. The expanded services would require adequate numbers of appropriately trained staff and structural refinements such as piped-in oxygen. In their new role, personal care homes/long term care centres could become training sites for all classifications of care givers.

At present, the increasing acuity of recent PCH admissions have significant staffing implications. Expensive professional staff need to be relieved of onerous record keeping duties. Accordingly, MHO's Long Term Care Management Information Systems project needs to be supported and encouraged by MHSC.

The role described above requires increased support from community services, hospital ambulatory care programs, and increased formal and informal links with acute care centres. Also, geriatric care/ long term care, whether provided in a long term care or acute care setting, must be seen as being of equivalent quality.

Within the rural juxtaposed facility, there are no barriers between long term and acute care, consequently patients are moved, as required, between the two services. We would support increased communication between urban acute and long term care facilities to enhance planned patient movement between the sectors.

We question the assumption in the report that PCH beds should not be increased and note that interim decisions have been taken to increase the number of existing extended care beds. We strongly urge that further study be undertaken to determine immediate and future PCH bed needs.

7. Funding

Boards recognize that patients are unaware of the value of services they consume. Accordingly, it is felt that efforts should be made to better inform physicians and patients regarding the cost of services consumed, whether annually or by episode of illness.

Medical administration activities performed by physicians are not funded in many of the province's facilities, acute and long term care. MHO recommends a review of this arrangement to ensure that all facilities benefit from physician input in this area.

Certain facilities have demonstrated initiative in delivering preventive (public health education) programs funded out of their global budget as part of routine services. This trend must be encouraged and permitted to grow through recognition by the funding agencies.

Personal care home boards are incurring significant costs in transferring patients to acute care centres for simple emergency procedures eg. suturing. Transportation and other costs could be

saved if additional medical procedures were performed in personal care homes and appropriate compensation was available for on-call physicians. Such arrangements should be subject to adequate control regarding the type of procedures performed.

Conclusion

It is recognized that hospitals are seen as the lynchpin of Manitoba's health system. Their curative role is administered separately from the preventive activities of public health agencies. The Ministries of Health and Community Services reflect this organization of the health system. If as the report suggests, prevention and primary health care are to be seen as equally important as curative care, then the Ministries of Health and Community Services must reflect this model in their structure. Additional resources must also be dedicated to the introduction and development of these services. Further, the role of the Ministry of Health should be seen as undertaking research; monitoring and evaluating projects; facilitating planning, and providing expertise to urban and rural regions to permit increased local innovation.

In summary, MHO recommends:

1. The development of secondary health care centres for preventive and curative care in strategic locations throughout the province. Their locations should be determined through study of the patterns of utilization across the province, and should provide the volume and type of services required to meet identified needs.

2. That exploration occur regarding the usefulness of case mix groups to project and contain costs.

3. That alternative delivery systems be defined and tested through trial projects with appropriate statistical monitoring and costing.

MHO is committed to continuing improvement and leadership in health care. Accordingly, the organization is willing to define the following roles for itself:

1. MHO has a significant role to play in providing education services to boards, their administrators, staff and when appropriate, the general public. MHO undertakes to provide information to boards to explore options and mechanisms for shared services, for example, the voluntary establishment of regional coordinating committees.

2. MHO has demonstrated a research role to ensure a proactive stance regarding health care issues. MHO will provide administrative and research support to facilities who wish to implement more sophisticated shared clinical and management services.

3. MHO is committed to the autonomy of volunteer boards and will respond to any initiative from its membership to expand the role of MHO's regional councils to include coordination/rationalization of services, provided that the individuality of each board is maintained.

Finally, we wish to point out that MHO plays a vital role in planning for health care in the province and should be represented on all such committees. Our representation on the Administrative Impacts Sub-Committee is appreciated and we look forward to a seat on the proposed conjoint planning committee. Our participation is seen as a valuable opportunity to demonstrate responsiveness to current health care issues.

APPENDIX

SUB-COMMITTEE	COMMENTS
Administrative Impacts	Support approach toward innovative alternatives and focus on ambulatory care.
Cardio-Vascular	Support increased education for nurses and public.
Continuing Care	With increased focus on ambulatory diagnostic, therapeutic services and home convalescence, continuing care is more important than in-patient services. Support need for improved staffing and coordination. Comparison with New Brunswick's Extra Mural Hospital could generate possibilities of wider role in urban and rural areas.
Critical Care	Acute staffing problems (training and funding) need correction. "Step-down" beds needed; blocked beds in less acute areas of hospital is part of the larger issue of continuum of care and increasing acuity of care.
Elderly	Concern with concept of "Dept. of Elderly". What is current role of LTC Division in MHSC? Agreed with need for more effective coordination of services: in-patient acute and LTC and community. Support need for review of panelling process in consultation with providers of care and increased flexibility in use of respite beds. Publicize through community education the availability of respite programs.

APPENDIX (cont'd)

SUB-COMMITTEE	COMMENTS
Emergency	Criteria for admission and discharge need to be explicit. Utilization review necessary to avoid emergency admissions becoming long stay, inappropriate admissions. Public education necessary regarding helmet, seat belt, drinking and driving. Home care support need to be consistent, available, accessible and flexible. Publicize home care support through public education.
Gastro-Intestinal	Upgrading facilities, equipment and staffing resources needed based on "mini-region" model but changes should be carefully considered to reduce increasing dependence on "testing".
Indian Health Services	Support application of principle requiring local client input into decision making. Applicable to all native populations. Need to rationalize, source of funding and provide education for new trustees.
Not-for-Admission Surgery	Continuity of care required. Freed beds should be used to reduce waiting lists, not "temporary" admission for those awaiting placement in long term care beds.
Obstetrics	Support expansion of ambulatory services; establishment of hostel accommodation for rural patients and pilot projects for alternate forms of patient management to reduce hospital stay.

APPENDIX (cont'd)

SUB-COMMITTEE	COMMENTS
Oncology	Support plans for increased use of NFA procedures, home care and dedicated beds. Hostel accommodation also appropriate.
Out-Patient Medical Services	Support formal ambulatory diagnostic and therapeutic programs. Patients will require increased home care support. Are group practices with diagnostic capacity cheaper than hospital-based services?
Pediatrics	More focus on primary care and prevention appropriate. Expand role of nurses to include neonatal nurse-clinicians and expand consulting neonatology services in rural areas.
Respiratory	Support diagnosis as part of ambulatory care. Expand/encourage use of inhalation therapy in PCH's with appropriate outfitting, staffing and training.
Terminal Illness	Train designated staff (rural & urban) in current approaches to multi-disciplinary palliative care. Encourage use of personal care homes, home care, and day hospitals for as long as possible. MHO supports need for Boards to develop policies supporting autonomy of patient and family.

THE MANITOBA ASSOCIATION OF REGISTERED NURSES

RESPONSE

TO THE

REPORT OF THE HEALTH SERVICES REVIEW COMMITTEE

June 25, 1986

Manitoba Association of Registered Nurses
647 Broadway, Winnipeg, Manitoba R3C 0X2 (204)774-3477

48

COURIER

July 3, 1986

Mr. David Pascoe
Chairman
Health Services Review Committee
308 - 294 Portage Avenue
Winnipeg R3C OB9

Dear Mr. Pascoe:

Re: Health Services Review Committee Report

The Manitoba Association of Registered Nurses is pleased to forward its response to the Report of the Health Services Review Committee.

Should you have any questions or wish any further information, please do not hesitate to contact our office.

Yours truly,

Sherry D. Wiebe

Sherry D. Wiebe
Executive Director

SDW/ab
enc.

c.c. E. Giffin

Manitoba Association of Registered Nurses
647 Broadway, Winnipeg, Manitoba R3C 0X2 (204)774-3477

THE MANITOBA ASSOCIATION OF REGISTERED NURSES RESPONSE TO THE REPORT OF THE HEALTH SERVICES REVIEW COMMITTEE

The MARN commends the Honorable L.L. Desjardins, Minister of Health, for his forsight in directing a major review of the health services in Manitoba. We wish also to commend the Minister for the democratic, collaborative approach used in accomplishing this task. We are pleased that the MARN had a representative on the Health Services Review Committee and that registered nurses were also represented on the subcommittees. Members within our Association have now had the opportunity to review the report of the Health Services Review Committee and their response is incorporated herein.[1]

The Manitoba Association of Registered Nurses strongly supports the continuation of the Health Services Review Advisory Committee so that the various recommendations of the Health Services Review Committee may be acted upon. Since the many recommendations have implications for nursing practice, education, administration and research, the MARN would be pleased to recommend expert resources in any of these four areas to assist the Advisory Committee. We agree that existing structures for dialogue, information sharing and coordination of health care services are currently inadequate and we believe that the proposed standing Committee with adequate membership and access to expert

[1] The MARN acknowledges the critique of members listed in the Appendix to this Response.

resources would provide an alternate communication structure. We will now comment on the recommendations arising from each Sub-Committee.

THE SUB-COMMITTEE ON CARDIOVASCULAR DISORDERS

This Sub-Committee urged utilization of trained nurse clinicians at St. Boniface General Hospital, Health Sciences Centre, and the Children's Centre.

The Health Services Review Committee supported this recommendation. The MARN agrees that experienced, qualified nurse resources should be used in their fullest sense. Naturally, there are implications for the nursing education system so that necessary support systems can be provided. We also support the important community outreach function that such nurses may undertake. We would further support the creative use of nurses in a role which would extend to the rural and northern areas of Manitoba. We also note that the rates of cardiovascular disease vary geographically within the Province and attention to this variation would target the extended use of the nurse in this role.

SUB-COMMITTEE ON CONTINUING CARE

It is with regret that the MARN noted the substitution of the content of community health with that of continuing care. It is in this area that our members noted the limitation of the Health Services Review

Committee overall. While the Health Services Review Committee must be commended on its efforts towards community outreach, the MARN recognizes a very large and very important role for community health nursing in relation to illness prevention and health promotion.

The expansion of ambulatory care into the community, while satisfying and important in relation to continuity of care, may perpetuate problems related to program based care. For example, if separate community outreach programs were to exist for cardiovascular care, geriatrics and maternal/child health it is conceivable that one family may receive services from several nurses all under the auspices of community outreach. A program focus rather than a family or community focus may continue to confuse both nurses and families.

The community health nurse practise includes a focus on the aggregate and interventions related to illness prevention and health promotion. The role of the nurse in illness prevention has been well documented, for example, in decreasing morbidity following myocardial infarction, adherance to hypertension regimens and skill learning for risk reduction. The role of nurses in health promotion is also accumulating evidence of outcomes. Some notable Canadian studies have described health promotion outcomes in relation to client self-care competency, changed family health care practices, increased health

problem-solving including options for health care systems entry, to mention a few. Community health nursing with its emphasis on the aggregate should not be confused with the type of community outreach that may be possible through the expansion of ambulatory care within the existing system.

Returning now to continuing care, the MARN does support the Sub-Committee's priority recommendation dealing with the interface between the hospitals and the continuing care program. This would provide a vehicle for care planning which currently is limited. In addition, since the area of community health received limited treatment, the MARN would be pleased to recommend to the Advisory Committee the necessary experienced nurse resources in order to examine the impact of Health Services Review recommendations on community health care systems. The MARN is currently reviewing the role of community health nurses and scope of community health nursing practice in Manitoba.

SUB-COMMITTEE ON CRITICAL CARE

The MARN agrees with the Health Services Review Committee that criteria for defining admissions to critical care units are required. Certainly, we are aware that the graduates of the MARN accredited Intensive Care Nursing Courses are in great demand. Such nurses have important roles in both urban and northern communities. The increased

and appropriate use of this nursing expertise, however, requires the use of appropriate admission criteria for critical care. The MARN continues to monitor with interest the various roles these experienced nurses continue to play across nursing care settings. We are especially interested in the description of this role in relation to the Air Ambulance.

Should the Minister wish to pursue the development of appropriate qualifications criteria for both medical and nursing personnel working in intensive care in rural and northern areas, the MARN would suggest nursing expertise as follows: nurse teachers of adult critical care and neonatal care, a northern practicing critical care unit nurse, a rural practicing critical care unit nurse, and a nursing administrator of an urban critical care unit. We would be pleased to recommend specific representatives in each of these areas.

SUB-COMMITTEE ON HEALTH SERVICES FOR THE ELDERLY

The MARN supports the various recommendations offered by the Sub-Committee on Health Services for the Elderly. Expanded respite care both within the institution but also within the home is essential to enhance the independence of the elderly and the independence of families caring for their older members.

Our members additionaliy recommended that the professional staff component of personal care homes be increased and that more work is needed to address the problem of care for the increasing numbers of elderly who are confused, aggressive and mentally incompetent. This latter area was not addressed in detail by the Sub-Committee, however it continues to provide a very great health care challenge.

SUB-COMMITTEE ON EMERGENCY HEALTH CARE

This Sub-Committee has identified many structural barriers to appropriate emergency health care.

The MARN currently accredits one emergency nursing course and graduates of this course may be found in emergency departments in urban, rural and northern areas. Certainly the MARN concurs that the problem of education of physicians, nurses, and others who provide emergency health care services must be reviewed by the appropriate educating bodies. The MARN has already noted in its statement on entry to the practice of nursing that a content review at both the undergraduate, graduate and continuing education level would identify core content and content for nursing specialities.

The MARN notes and approves the Committee's recognition of the importance of public awareness of risk reduction. We do note that despite

public awareness strategies, accidents and cardiopulmonary disease persist at high levels across all ages. This large literature on preventive strategies has been well addressed by epidemiologists and health educators. The health educators conclude that information alone, without the necessary skill building strategies, is inadequate to reduce disease due to lifestyle factors. The nursing literature has demonstrated that nurses are particularly successful in engaging their patients and clients in appropriate skill building strategies.

SUB-COMMITTEE ON GASTROINTESTINAL DISORDERS

The MARN supports the recommendation of the Sub-Committee on Gastrointestinal Disorders for expanded ambulatory diagnostic testing and expanded NFA surgery capacity. Additional comments are offered in regard to the Sub-Committee on Not For Admission (NFA) Surgery.

SUB-COMMITTEE ON INDIAN HEALTH CARE

The Indian Health Care Sub-Committee recommended that both government and health professional licensing associations should deal with the continuing need for nurse practitioners to work in isolated locations. The Manitoba Association of Registered Nurses notes with interest the educational and health care practitioner developments in Manitoba, including innovative educational programs for nurses in Northern Manitoba. The MARN continues to support the development of needed educational outreach and resources to the North.

The MARN is currently developing recommendations with regard to health practitioner roles including those of the Nurse Practitioner, that is, registered nurses credentialled as Nurse Practitioners. The use of Nurse Practitioners has proved efficacious in many health care settings and should also prove efficacious in the North providing the educational process includes culture specificity. Resources already exist in Manitoba for culture specific education. These should be made available for university credit to Nurse Practitioners.

MARN members have also noted that it is important not to equate concepts of quality of health care and other necessary socioeconomic resources. While overcrowded housing, poor water and sanitation and high unemployment contribute to the ill health of Indian people, these problems will not be resolved by increasing the availability of health care practitioners.

SUB-COMMITTEE ON NOT FOR ADMISSION (NFA) SURGERY

The MARN is pleased that the systematic development of NFA Surgery services is supported by the Health Services Review Committee. The MARN has recently published Perioperative Nursing Standards (1985) which will be useful in guiding the practice of perioperative nursing in rural and urban hospitals as well as in NFA surgery units. This nursing role certainly fits within the recommendations for (1) pre-admission evaluation, instruction and preparation of the patient,

(2) pre-operative anaesthesia assessment, (3) a post-operative recovery room and observation area with dedicated staff; and (4) provision for post-operative follow-up including home nursing visits. The MARN Standards describe the nursing role in each of these four areas. The full use of nurses within the perioperative role as described within the MARN Standards would require attention to the structure for health care delivery and the allocation of funding within it.

SUB-COMMITTEE OF OBSTETRICS

The MARN notes with interest the recommendation to train neonatal nurse clinicians. It currently accredits a Neonatal Nursing Course at Health Sciences Centre. As with other continuing education courses, the MARN has recognized the need for an examination of basic and post-basic content. Thus, the implications for additional nurse education reach far beyond continuing education in both philosophy and resources.

The MARN is currently examining the role of the registered nurse midwife and has made recommendations in this regard to the Manitoba Council on the Status of Women. Approximately 50 nurses have currently enrolled in the Manitoba Association of Registered Nurses Roster of Registered Nurse Midwives. These many nurse obstetrical resources should be well used in regard to the Health Services Review Committee Report recommendations.

SUB-COMMITTEE ON ONCOLOGY

The Oncology Sub-Committee recommended that Oncology nursing be developed in this Province as a speciality to produce improved patient care in both out-patient and in-patient settings. The MARN is currently reviewing criteria for categorizing nursing specialities. It notes that oncology nursing meets three requisite criteria: (1) developing standards, (2) a research base and, (3) an undergraduate course in palliative care at the University of Manitoba School of Nursing. The MARN currently has an ad hoc committee to develop oncology nursing standards based on the MARN Nursing Standards (1981). Its membership includes nurses from both in and out-patient settings and across oncology treatment services.

The Oncology Sub-Committee also recommended that there be a larger role for nurses in public education and cancer preventive programs. Basic to public education is well researched information. The MARN has contributed funds to two Manitoba nurse researchers to facilitate the development of a Western Cancer Nursing Research Consortium. This project is intended to target priorities for cancer nursing research. The Research Consortium is also intended to demonstrate collaborative research and make maximum use of available research resources. Nursing is certainly ready to assume a larger role in oncology services and the MARN will continue to monitor the development of emerging specialities.

SUB-COMMITTEE ON OUT PATIENTS

Ambulatory care services present interesting challenges to health care practitioners, administrators and educators. The MARN fully supports the Sub-Committee recommendation that four model ambulatory services be established as models to serve as teaching locals. The four models include the two tertiary teaching hospitals out-patient departments in Winnipeg, one community hospital out-patient department, and one community oriented primary care program. Effective ambulatory care nursing roles have already been established in Manitoba.

The MARN is aware that nurse resources do exist but in many cases are under utilized in ambulatory care facilities. Ambulatory care in particular provides the opportunity for interventions directed toward risk reduction, illness prevention and health promotion. Nurses who have a strong generalist educational background and, in specific areas, Nurse Practitioners, have been demonstrated as providing effective health care services. The MARN also notes that specific community outreach projects can arise from ambulatory care services and supports this development and its evaluation as an adjunct to community health services.

SUB-COMMITTEE ON PEDIATRICS

The MARN notes with interest the recommendation regarding the education of neonatal nurse clinicians and has already commented on the currently accredited MARN Neonatal Nurse Clinician Continuing

Education Certificate Course offered at the Health Sciences Centre. Aside from the neonatal nurse services, the MARN is aware of the problem of scarce nurse resources in pediatrics in Manitoba.

The MARN notes that suggested improvement in the system seems to be aimed at the intensive areas for critically ill children, cardiac unit development, oncology unit development, and neonatal nurse specialists. There is little emphasis on illness prevention and health promotion. For example, a review of childrens' respiratory disease statistics shows high morbidity, both chronic and acute. Many of these children are from the North, beyond the age of neonatal concern, and have not yet reached the chronic lung stage but do require some particular focus of follow-up. The MARN also supports the concept of the use of qualified, experienced nurses, especially Pediatric Nurse Practitioners who have already made inroads in some parts of rural United States in this important area. The educational implications for Manitoba are many.

The Pediatrics Sub-Committee also recommended that both health professionals and the public should be made aware of the costs of the present health care system and an assessment of the public education programs effect on utilization of health care systems should be made. The MARN fully supports this recommendation and will proceed with the education of its members in this regard. An information series in

issues of the MARN newsletter is planned. Each of the over 9,000 registered nurses in Manitoba receives this newsletter.

Additionally, the MARN would be pleased to participate in public education programs. MARN is aware of several registered nurses who are experienced in educating the public on how to use the health care system and would be pleased to participate in an interdisciplinary program.

SUB-COMMITTEE ON RESPIRATORY DISORDERS

The MARN supports the Sub-Committee on Respiratory Disorders recommendation that ventilation of patients in personal care homes occur provided the professional nursing staff component be increased. An additional consideration is the quality of life space which would allow adequate socialization for both smokers and non-smokers in personal care homes where oxygen is used.

SUB-COMMITTEE ON THE TERMINALLY ILL

The MARN notes that the Sub-Committee's recommendation to create the hospice as an addition to the number of institutional places available for the care of the terminally ill patient was not accepted by the Health Services Review Committee. While there may be sufficient institutional beds available for the care of the terminally ill in Manitoba, care within an institutional structure

may not address the quality of life needs of the terminally ill. The MARN notes that there are concerted efforts to provide quality of life to the terminally ill within at least three Manitoba institutions. However, the MARN also notes that the terminally ill are also cared for in institutions which do not have the recognized professional and structural supports. Despite current knowledge, we continue to note that people die in pain when they need not. Although the concept of the hospice has been rejected by the Health Services Review Committe, the MARN would urge that the concept of quality of life be reflected in all services for the care of the terminally ill.

In conclusion, the Health Services Review Committee has demonstrated that provincial collaboration for health care change can occur. The next important step will be the demonstration of implementation of the recommendations: a step that is frequently absent or limited in the life of many reports. The MARN urges the Honorable L.L. Desjardins, Minister of Health to support the Health Services Review Advisory Committee and that this Committee be adequately and appropriately structured with nursing resources.

25-6-86

Appendix

The MARN wishes to acknowledge the critique of the following members who are listed below.

Mrs. J. Anderton
Director, Public Health Nursing
City of Winnipeg Health Department

Dr. Janet Beaton
Coordinator Graduate Program
University of Manitoba School of Nursing

Mrs. Donna Blight
Past Registrar - 1985/1986
Manitoba Association of Registered Nurses

Ms. Maudrene Butters
Director of Nursing
Golden Links Lodge

Mr. Dean Care
Director, Nursing Education
St. Boniface General Hospital

Miss Tina Enns
Director, School of Nursing
Misericordia General Hospital

Ms. Pat Farrell
Nursing Consultant-Practice
Manitoba Association of Registered Nurses

Ms. Dorothy Froman
Nursing Consultant-Education
Manitoba Association of Registered Nurses

Ms. Linda Kristjanson
Assistant Professor
University of Manitoba School of Nursing

Dr. Jenniece Larsen
Director, School of Nursing
University of Manitoba

Ms. Cathy Lovatt
Chair
Manitoba Community Nurses Interest Group

Ms. Beth Ritchie
Director, Manitoba Emergency Nursing Course
Health Sciences Centre

Mrs. Susan Roe
Assistant Professor
University of Manitoba School of Nursing

Ms. Gloria Steuart
Member, MARN Clinical Majors Committee

Ms. Carolyn Vogt
Director-Nursing Education
Grace Hospital School of Nursing

Ms. Mollie Willard
Director of Nursing
Bethania Mennonite Personal Care Home

Ms. Marilyn Whiteley
Co-ordinator, Neonatal & Pediatric Critical Care Course
Health Sciences Centre

mona
manitoba organization of nurses' associations
8-1313 border street
winnipeg, mb R3H 0X4
(204) 632-6605

June 30, 1986.

Mr. David Pascoe, Chairman
Health Services Review Committee,
308 Somerset Place,
294 Portage Avenue,
Winnipeg, Manitoba.
R3C 0B9

Dear Sir:

The Manitoba Organization of Nurses' Associations (MONA) is pleased to have the opportunity to respond to the Health Services Review Committee Report. On behalf of MONA we respectfully submit the enclosed document for your consideration.

Sincerely,

Vera Chernecki

Vera Chernecki, R.N.
President.

MANITOBA ORGANIZATION OF NURSES' ASSOCIATIONS

SUBMISSION TO THE

HEALTH SERVICES REVIEW COMMITTEE

IN RESPONSE

TO THE HEALTH SERVICES REVIEW COMMITTEE REPORT

JUNE 30, 1986

INTRODUCTION:

The Manitoba Organization of Nurses' Associations (MONA) is an independent labour organization established in 1975. MONA represents 85 bargaining units (MONA Locals) that are certified under the Labour Relations Act of Manitoba. Total membership approximates 9,479[1] at this point in time and includes the majority of the unionized registered nurses and licensed practical nurses in the province. Included as well are some registered psychiatric nurses (employed in personal care homes or in psychiatric units of some general hospitals) and some operating room technicians employed at Health Sciences Centre, Brandon General Hospital, Neepawa District Memorial Hospital and at Portage District General Hospital. Graduate nurses (non-registered and graduate pending license nurses) are also included in the bargaining units.

MONA's response to the Health Services Review Committee Report is in keeping with the "reason for being" of this organization as defined in its objectives:

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1. Approximated breakdown: RN - 7126, LPN - 2180
   RPN - 139, ORT - 34

"The object of the MONA shall be the advancement of the social, economic and general welfare of its members including particularly the following:

(a) To regulate the employment relations between its members and their employers including particularly, the negotiations and enforcement of collective agreements between them.

(b) To promote high professional standards of practise and appropriate working conditions with a view to achieving the best attainable patient care.

(c) To encourage the education of its members in such manner as may be deemed advisable to achieve these objectives."

The past few years have seen much discussion among MONA members about the modernization and improvement of the health care system. As outlined above, an important objective for us is attaining the best quality of patient care.

We commend the Health Services Review Committee for its thorough and comprehensive review of the health services delivery system in Manitoba and for completing its Report.

Our submission does not include a response to each recommendation of the Health Services Review Committee, although some will be dealt with specifically. For the most part the submission is in the form of a general position regarding what MONA sees as necessary for the future direction of a cost efficient, quality care oriented health care system for Manitoba.

PRESERVATION OF MEDICARE

MONA believes that access to quality health care for all Manitobans is a basic right. We have lobbied hard and worked diligently to ensure that the basic principles of Medicare are preserved. Our thrust stems from a conviction that any health care system should be based on a set of commonly understood principles:

- That all people have the right to good health.
- That all people have the right to health care.
- That all people have the right to participate effectively in health decisions.
- That the health system should foster personal initiative and responsible lifestyles whenever possible.
- That while financial factors are important, the human and social values at stake should be given priority in making health care decisions.

We must look to a direction for the future which will provide quality health care at a cost we can afford in a system free of deterrants such as user fees, extra billing and premiums.

NEED FOR A NEW DIRECTION

In their review, the Health Services Review Committee perceived that the province's ability to respond to health care delivery needs in Manitoba could be directed in one of several ways. These included:

1. More money for more of the same services; or,
2. Rationing of health care resources; or,
3. Develop innovative alternatives of treatment and prevention to the present emphasis on in-patient services.

The Health Services Review Committee concluded that the third option was the way to proceed and MONA strongly supports this option. We have previously gone on record as supporting a need for reform of the health care system with the objective of improving the system, both from a cost efficiency and a cost benefit point of view.

In 1985 at the Annual Meeting of MONA, delegates approved a resolution that called for MONA to support the need for reform of the health care system to change the emphasis from the curative to the preventive approach.

This resolution also endorsed MONA's support of the community health centre concept which would provide primary health services and which would be staffed by a salaried team of physicians, nurses and other health care workers.

CHANGING THE FOCUS OF THE SYSTEM

We must focus more and more on a system which promotes health and prevents illness. The current system is geared to focus on sickness and curative treatment. "Health Care" is most often defined as the provision of medical services to an individual who physically manifests ill health. Typically, this service is used to intervene at or near the crisis point rather than at an earlier point where the crisis could have been averted. It is at the point of crisis rather than at the prevention point where the bulk of high cost treatment is applied. It is also at this point where symptoms rather than causes are treated.

Thus while the curative approach leads to provision of necessary services, it is by no means a sufficient basis for promoting total health of individuals or communities. We must reach people where they live, work and play. We must assist the public in assuming more responsibility for their own health by promoting total well being. Prevention is only part of the problem of keeping people healthy. Cultivating good health involves healthy lifestyles, a healthy environment and avoidance of unhealthy habits such as smoking, alcohol and drug abuse.

To begin with, more of this health teaching must start at an early age - programs of education in proper nutrition, benefits of exercise and fitness, stress management and healthy lifestyles in general need to be implemented in schools.

Employers should be encouraged to promote health and to sponsor health programs. Generally employee well-being means lower absentee rates, higher morale and increased productivity.

MONA believes that community health centres can play a major role in the reform of the system. They should be under the control of a Board of Directors composed of members of the community, worker representatives etc., which would be responsible for detailed planning, priority setting and preparing and administering of budgets in line with the needs of the community they serve. We believe that the centres should be staffed by a competent, salaried team of physicians, nurses, technologists, therapists, home care workers and other health care personnel who would work together to plan and deliver services to restore, preserve and promote the health of the community they serve.

Early detection screening services for diabetes, hypertension or visual problems could be services provided by community health centres. Monitoring of an individual's health status on a regular basis could also be done from this base.

Programs sponsored by community health centres could play a major role in preventive health care with the elderly in our society.

In summary, by community health centres providing primary health care services, the demand for high cost hospital services will be decreased. The centres can also play an important part in the education process and in disseminating information to promote health and prevent illness. Preventive health care produces healthier, more productive individuals, at less cost in the long run.

In looking at a redirection of the health care system, MONA is supportive of expansion of home care support services, which will allow increasing early discharge programs from hospitals for all age levels of patients. Adequate home care support services, possibly co-ordinated from a community health centre, would maintain more elderly in their homes.

With the ability of being able to move patients out of acute care beds sooner, the chronic overcrowding in urban and tertiary hospital emergency departments would be alleviated. Dangerously long waiting lists for surgery would also be eliminated.

EXPANDED ROLE FOR NURSES

To organize a health system which will provide effective and genuine "health" services it is essential that we make the best use of all professionals. One way to improve the health care system is to give nurses an expanded role. Accessibility, for example could be vastly improved if nursing were included in the list of insured services. Nurses, as an alternative point of first entry into the health care system, can provide direct access to nursing care without adversely affecting the quality of patient care.

In many cases, an individual does not require the services of a doctor. Right now, those people requring nursing services, such as monitoring and/or teaching related to heart conditions, diabetes and hypertension must first be admitted to hospital, because nursing is not an insured service. In situations involving necessary home care services, the individual must be referred by a doctor.

It has been well documented by the Canadian Nurses' Association that nurses can and do provide services in a variety of settings that represent lower cost alternatives to the current physician and hospital based system.[2] Several cases have also documented that nurses can provide better qualtiy care.[2]

The 1980 Hall report clearly demonstrated that the use of health care professionals such as nurses has a positive effect on access to, cost and quality of health care. Direct access to nurses would cut health care costs, without cutting the quality of service to individuals.

The Canada Health Act provides direction for a future health care system which is more preventive, community-oriented and multi-provider, by the introduction of the concept of "health care practitioners". MONA has been directed by membership to lobby the Provincial Minister of Health to amend provincial legislation to permit insured services provided by other health care practitioners such as nurses, as well as medical practitioners. We urge that such an amendment be supported by the Health Services Review Committee.

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2. Canadian Nurses Association - Canada Health Act Bulletin - 1983.

VARIOUS LEVELS OF NURSES REQUIRED

MONA strongly supports that an innovative approach to a more cost efficient health care system must include all levels of nurses i.e. registered nurses (diploma and baccalaureate prepared) licensed practical nurses and psychiatric nurses. We believe that the various prepared levels of nurses can provide a valuable contribution to the health care "team", including care co-ordinated from community health centres.

On a similar note, MONA recognizes the value of the Operating Room Technicians (ORTS) in the health care system now and in the future. ORTs contribute to quality patient care in the operating room in a cost-effective way. ORTs are generally paid in accordance with the Licensed Practical Nurses scale. They undergo an intensive training program for 12 months which is an integrated course of theory and clinical practise in operating room technology. Their numbers have dwindled in the last few years due to decreasing job opportunities in some hospitals. MONA strongly supports a continuing role for ORTs.

Intensive Care Nurses

This whole area must be addressed, not only from an urban and tertiary hospital point of view but for northern and other rural Manitoba hospitals as well. MONA would be pleased to collaborate with the appropriate groups in efforts to recruit adequate numbers of intensive care nurses. Adequate opportunities for training and compensation during training must be addressed. Properly compensated Intensive Care nurses are still more cost efficient than funding for physicians to cover in intensive care units.

Specific to Northern Manitoba facilities:

The closure in 1983 of the intensive care unit at the Flin Flon General Hospital and an alleged resulting dealth, drew attention to the fact that northern Manitoba health care facilities are having difficulty attracting qualified intensive care nurses. At present, the only intensive care training courses are available in Winnipeg - at the Health Sciences Centre (9 month course) and at the St. Boniface Hospital (7.5 month course). It is not feasible to expect northern nurses to relocate to Winnipeg for seven (7) to nine (9) months to obtain this type of training. MONA members feel very strongly that residents of northern Manitoba also have a right to quality care and that health care facilities which have intensive care units should ensure that these units are staffed 24 hours a day.

We understand a study conducted after this incident in Flin Flon outlined specific recommendations to improve the situation. These have apparently not been implemented and we question why this is the case.

Obstetrical Services - City of Winnipeg

The closure several years ago of the obstetrical units at the Concordia and Seven Oaks Hospitals has been the subject of much discussion by MONA members since that time. Many concerns have been expressed that the cost saving that was to be realized from the closure has not led to an overall improvement in obstetrics services. Both St. Boniface Hospital and Health Sciences Centre obstetrical units are still strained to capacity.

MONA members feel strongly that community hospital obstetrical units must remain accessible to expectant familites. They feel that centralization of obstetrics services in Winnipeg has gone far enough and that obstetrics units at the Victoria, Grace and Misercordia General Hospitals must not be closed.

REGIONALIZATION OF HEALTH CARE SERVICES

As a long term reality, MONA members see the cost-benefit of looking at more regionalization of health care services. Rather than a small, under-utilized hospital in every community, there may be merit in proceeding to regional health centres, which would provide services related to acute care, as well as preventive community health care. Well equipped, modern centres offering a wide range of services might be more attractive to physicians, nurses and other health care workers alike.

These centres should be administered by boards which have a multi disciplinary membership - members of the community, members of employee groups, physicians etc. This will ensure that the many varied interests of the community are well served.

Another benefit to be realized from this concept would be that the more acutely ill people could stay closer to their own communities rather than being transferred into large urban centres. A wide range of home care support services could be co-ordinated from these centres. Emphasis should again be on the promotion of health and prevention of illness concept. Some of the rural hospitals could be converted and more appropriately utilized as personal care homes.

A move to more regionalization of services goes hand in hand with improved ambulance services. Properly trained staff and properly equipped ambulances must be on standby at all times to ensure safe care for individuals requiring transfer to the regional health centres. MONA also urges that all ambulance services should be fully insured and that all patients requiring transfer by ambulance not be charged any costs.

CONCLUSION

In summary MONA believes that the time to begin reform of health care system is now. This reform must include a move away from the crisis oriented hospital based system to a preventive community support system. This reform must include an intensive public education program so as to allow broad acceptance.

We can no longer afford to not reform the health care system. In the short run, funding may have to increase for proper reform to take place; however, in the long run the result will be a cost-efficient, quality care oriented health care system.

MONA is committed to providing input to the appropriate government bodies for the orderly planning and implementation of changes related to this reform of the system.

Manitoba Association of Licensed Practical Nurses

July 3, 1986.

Mr. David Pascoe,
Chairman,
Health Services Review Committee,
308 - 294 Portage Avenue,
Winnipeg, Manitoba.
R3C OB9

Dear Mr. Pascoe:

The Manitoba Association of Licensed Practical Nurses welcomed the opportunity to comment on the final Report of the Health Services Review Committee and looks forward to participation in the future development of the Health Care System. A system which will provide high quality, affordable and accessible health care services to the citizens of Manitoba.

We apologize that our response is a few days late but trust it will be considered by the review committee.

Sincerely,

Verna Holgate

(Mrs.) Verna Holgate, LPN
Executive Director,
M.A.L.P.N.

VH/dj
Encl.
cc R. Jacuk, MALPN President

Manitoba Association of Licensed Practical Nurses

Response to

The Report of the Health Services Review Committee

June, 1986

The Manitoba Association of Licensed Practical Nurses (MALPN) welcomes the opportunity to respond to the Report of the Health Services Review Committee (RHSRC). The MALPN Board commends the Honorable Minister of Health, L. L. Desjardins, for recognizing the need and taking the initiative to examine current and future health care issues. We have been aware for sometime that the health care industry is experiencing significant cost constraints with little or no indication of any relief from the severe financial restrictions in the immediate future. Therefore, the need to consider alternatives without sacrificing the quality of care provided to the citizens of Manitoba is essential.

We recognize the Committee undertook an arduous task and commend their efforts in researching and proposing changing the focus of health care services in Manitoba.

The MALPN agrees with the committee's suggestion that to provide cost effective quality health care for Manitobans is a challenge for the entire health care system. Therefore we noted with interest within the committee and sub committee structure the obvious absence of representation from other major contributors such as social workers, physiotherapists, Registered Psychiatric Nurses and Licensed Practical Nurses. It must be recognized that any changes to the traditional modalities of care and cure will ultimately impact on all providers of health care services; and not just isolated to physicians and registered nurses.

Although the global term "nurse" was reflected throughout the report; rather than make the assumption that Licensed Practical Nurses were ignored, MALPN has chosen to believe the term "nurse", when used, encompasses LPNs as well as RNs.

Although we regret MALPN was not provided the opportunity to participate in the initial review process we acknowledge that many of the sub committee recommendations have merit and deserve further consideration and possible implementation.

The health system is composed of three elements - cure, care and education. However, currently the majority of time, effort and money is expended in the area of cure with minimal resources being directed in the areas of care and preventative education. Therefore the overall theme of the report to redirect both financial and human resources to these vital areas of the system is laudable.

The recommendations of numerous sub committees that alternative delivery modes which include increased public education, health promotion and prevention is supported by MALPN.

The recommendations related to ambulatory diagnostic screening and NFA procedures, including increasing and expanding the availability and accessibility of these services, is a viable solution to the concerns raised regarding the utilization of acute care beds.

We agree with the suggestions of several sub committees that community based services should be expanded. However, careful planning will be necessary to ensure that the transfer of services from institutional settings coincides with the establishment and implementation of programs within the community. As well, the current limitations in the home care program must be addressed. It must be recognized that in order to maintain individuals (especially the elderly) within the home setting, 24 hours/seven days per week services may be necessary if such a shift is to be successful.

Licensed Practical Nurses, throughout the province, currently are employed by continuing care to provide nursing services to the elderly and in a lesser degree to the physically or mentally impaired. Unfortunately, in most instances the system presently does not capitalize on the abilities of the LPN; most are working well below their potential. In addition, restricting the utilization of the Licensed Practical Nurse within the community to the above stated areas is, we believe, inappropriate misuse of available and qualified manpower. For example, MALPN believes LPNs could play a major role in the care of the terminally ill. The potential for growth of the LPN within this framework should not be impeded by artificial barriers imposed (as currently exists) by the health system bureaucracy. We suggest that, rather than restricting, it would be more cost-effective to expand the utilization of existing providers (i.e., RNs and LPNs). In fact, MALPN believes it is essential to the success of community-based services.

The MALPN agrees the existing services provided by Personal Care Homes and Long Term Care facilities should be expanded and support the suggestion that the use of personal care homes as a "point of no return" should be changed. Currently, the major focus is to provide therapeutic services geared at assisting the individual to obtain an optimum level of independence within the personal care home setting. Notwithstanding the importance and necessity of these services, personal care homes could broaden their focus to include rehabilitating individuals, with the potential to a level of self-care which would permit them to return to the home setting. This desirable objective could not be achieved without increasing professional staff including RNs, LPNs, occupational therapists and social workers. In addition, the recommendations related to increasing specialized services (e.g., oxygen therapy and tube feeding) should be implemented.

The MALPN acknowledges that many of the Obstetrics and Pediatric sub committee recommendations warrant consideration and strongly support the expansion of the role of both Licensed Practical Nurses and Registered Nurses in these vital areas of health care delivery.

The association agrees that information sharing and co-operation of health care services, as presently structured, is inadequate. There is a definite need for all components of the health care delivery system to initiate, develop and maintain communicative and co-operative linkages to ensure that an effective network of services can become a reality.

The MALPN advocates the development of a health care system that will allow the initiation of programs which will provide viable alternatives to institutional care, that will make more efficient use of all existing health care personnel, while ensuring Manitobans receive accessible high quality cost effective health care services.

The Manitoba Association of Licensed Practical Nurses which represents a large segment of the "nursing" population is committed to actively participating in the development of the health system. Therefore we would welcome the opportunity for input into the ongoing review of the system and look forward to receiving representation on committees established to review nursing services.

June 24, 1986

Mr. D. Pascoe,
Director Research and Planning Directories,
Manitoba Health,
308 - 294 Portage Avenue,
Winnipeg, Manitoba.
R3C 0B9

Dear Mr. Pascoe:

Our association would like to firstly thank the Hon. L.L. Desjardins for giving our association an opportunity to make comments on the Health Services Review Committee Report. Secondly, we wish to thank you Mr. Pascoe as chairman of the Review Committee for allowing us to submit our comments to your committee.

Under the report of emergency care our association is making comments on the section dealing with pre-hospital care and the delivery of that care. We have submitted some comments on preventive medicine and health. I have divided up our comments into three sections, each section contains comments on the recommendations made by the sub-committee to the Review Committee.

Section one is the recommendations which involve the standardization of the delivery of emergency care. The following are our comments on the recommendations made by the sub- committee:

> Our association supports the appointment of a medical director for the provinces emergency services. Different members of our association have worked with the present provincial medical director already and we feel the present director is doing a good job of setting up guidelines for levels of training for pre-hospital care workers. An important set of guidelines which the medical director and the Pre-hospital Care Advisory Committee are working on now is going to be very helpful. That is, training levels which will enable CMA level one ambulance personal an opportunity to use CMA level two skills. This opportunity for an ambulance service to use level two skills is a good step forward for rural EMS systems that are a far distance from a hospital and their service is not large enough to have full time people which would enable the service to have CMA level two ambulance attendant. An example of level one CMA ambulance personal using a CMA level two skill, is the use of MAST suits. A service that is forty minutes from the nearest hospital has a patient who is in hemorrhagic shock, the trousers will get the patient to the hospital with very good chance of recovering. This EMS service may be a volunteer service, but as long as they take the required training and meet protocols set up by the provincial medical director, this small service can use more advanced skills under the watchful eye of their own medical director and the provincial director.

Our association would like to comment on the role of the provincial medical director training also physicians in emergency care. In rural Manitoba at present it is

sometimes hard to find doctors who are up on ACLS & ATLS training. If you have a community that has physicians that do not completely keep up to-date in advances in emergency health, this in turn makes any advancement for an ambulance service difficult. At present the provincial medical director and the Pre-hospital Care Advisory Committee are making advanced skills more available to ambulance services. But these skills can only be put into place by local medical involvement, which is only proper, but if your local physician does not know what shock trousers are then your ambulance service is going to have a hard time getting this skill into place. We strongly hope that the medical director is given good cooporation by physicians in regards to training of different levels of emergency care.

We would like to comment on the recommendation of the medical director developing protocols on delivery to emergency care and transportation. When we look at delivery of EMS we start from the call for help, then the dispatching, responding of first responders, then ambulance and then emergency department and finally Life Fight. We suggest that when these types of protocols are eventually set up, that all people involved in this delivery system are given a chance to help set up protocols. Our association at present has some well prepared information on the subject of delivery of EMS, which we hope to present this summer to the minister of health. The following are comments on transportation. Our association supports the recommendations of the sub-committee saying that problem areas like the example the sub-committee has listed should be addressed immediately.

This problem also exists in some areas of rural Manitoba, where inefficient emergency response plans for ambulance services are in place at present for responding to a major incident. This type of problem comes into form as well as at times a community sends an ambulance to a bigger center on a patient transport leaving their community without an ambulance for that period of time. The community is left without an ambulance and needs a back up system.

Section two is the recommendations which involve Pre-hospital care. The following are our comments on the recommendations made by the sub-committee:

> The recommendations on WAS going to a level CMA three is a good recommendation. As long as the EMS system is set up in proper levels with the paramedic level being the highest level.
> The remainder of the recommendations by the sub-committee mainly focuses on using a hospital size to determine what type of training should be offered and where ambulances should be stationed from. Our association has always used call ratio as a base to determine whether a community needs a full time, part time or volunteer service. Also what types of training is governed by call ratio, and advancement is always left open to any EMS system whether they have a large amount of calls or not. Evaluating of the services and it's needs are used in evaluating an EMS system that does only 30 calls a year, yet wants to use defibrillation in the field.
> We strongly support the recommendation of the levels of training for different size hospitals, but what we are saying is we would sooner like the call ratio used in determining this factor. The recommendation that all service

with a 60 bed hospital should have hospital based ambulance services, is not supported at all by our association. We strongly feel there is room in this province for three levels of delivery in ambulance systems. That is socialized ambulance (hospital, government run) municipal run (fire, city, urban) and private ambulance services. As long as these services provide a good strong service and meet all health requirements, there should be room in Manitoba as a whole for all three levels of ambulance services. We feel that the recommendation of hospital based ambulances is very good in the form of providing a place for education and continuing education. If a service is running a CMA level two service, they should work very closely with their hospitals in setting up education and the all important continuing education. This hospital available training can be made available to ambulance services who have hospitals which are under 60 beds; especially with emergency care being given more attention by hospitals in the province.

Our association uses call ratio to determine levels of training and sub-committee uses bed size, but we have one common point which is very important for Manitoba, that is the fact levels of training and types of services have to change in Rural Manitoba's EMS systems. Our association is over whelmed that we have found a group of people who have the same concerns regarding EMS in Manitoba. We are happy to see people like the Review Committee make recommendation in the same form that our association has been working on for three years.

Section three is the recommendations which involve preventive medicine and health. The following are our comments on the sub-committee recommendations:

We strongly support all the recommendations of the sub-committee under preventive medicine. Our association has supported the Manitoba ALIVE program since the program has started, and we continue to support the programs like the ALIVE program. Promotion of basic CPR and even First Aid is very important if one wants to build and develop a delivery system of EMS. Education in the workplace is very important as well.

We thank you once again for giving our association a very important opportunity to comment on the possible future of EMS in the province of Manitoba. When future building starts we hope that the Health Serives Review Committee and an association like ours, is involved in building Manitoba's EMS.

Yours sincerely,

Ron Forsman

Ron Forsman,
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R7N 3A4

RF:bjh

cc: Hon. L.L. Desjardins

Health Sciences Centre

OFFICE OF THE CHAIRMAN

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July 21, 1986.

Mr. David Pascoe,
Chairman,
Health Services Review Committee,
308 Somerset Place,
294 Portage Avenue,
Winnipeg, Manitoba.
R3C 0B9.

Dear Mr. Pascoe:

Firstly may I thank you for the privilege of having the Health Sciences Centre respond to the Report of the Health Services Review Committee. It was an in depth study indeed, and you and your Committee are to commended for undertaking this mammoth task. It is a step in the right direction.

I am now pleased to enclose the Centre's response thereto for your Committee's consideration.

May I also add that our President, Mr. A. R. Thorfinnson and I would be more than pleased to arrange a personal presentation before your Review Committee if that is your wish. Members of our ad hoc Committee who were charged with the responsibility of drafting the Response, would be more than pleased to lend their support as well. However this would be entirely at the discretion of your Committee. Should this be your wish, a mutually satisfactory time could be arranged.

Yours very truly,

W. JOHN A. BULMAN,
Chairman.

WJAB:VMcD.
cc: Mr. A. R. Thorfinnson
Dr. John M. Horne

Response of the Health Sciences Centre to the Health Services Review Committee Report

General Observations

1. The HSC commends the Minister of Health for his earlier initiative in establishing the Review Committee and mandating it to examine current issues in Manitoba's health care delivery system and to recommend directions for its future development.

2. The HSC views the Committee's Report as the product of a positive process notable for its structured involvement of a diverse group of health care professionals in systematic consultation, deliberation, and review.

3. The HSC agrees with the Review Committee that the cost-effective provision of quality health care is a challenge for the entire health care system and, accordingly, sees significant merit in the Review Committee's proposal "that the Minister continue to actively seek the assistance and counsel of the broadest constituency within the health care field in order to assure that the recommendations and proposals outlined in the Report can be translated into practical reality". However, the HSC sees no reason to confine such continuing assistance and counsel to the contents of the Committee's Report. Rather, it should be sought on the more compelling grounds that effective health services review must be a continuous, not episodic activity, and that structured, systematic consultation with knowledgeable individuals and groups outside government is essential to success in the overall planning and management of the Province's health care system.

4. The HSC shares the Review Committee's stated overall preference for a system-wide resource management strategy stressing "innovative alternatives of treatment and prevention to the present emphasis on in-patient services".

5. The HSC notes a general conclusion of the Committee that the number of acute care beds in Winnipeg "is adequate if additional non-bed linked and community support services are made available". While not disagreeing, the HSC would caution that the necessary adjustments are complex, requiring not only additional resources for ambulatory care and community support services, but also unprecedented efforts to coordinate and harmonize the policies and practices of otherwise independent institutions and agencies.

July 21, 1986

6. The HSC strongly agrees with the Review Committee that there will be a "need for transitional funding to accomplish the proposed change for the health care system". Innovative programs in ambulatory care and community-based support services must be funded at realistic levels to demonstrate their full potential for cost-effectiveness.

Specific Observations related to Sub-Committee Reports

Sub-Committee on Administrative Impacts

The Health Sciences Centre notes that this Sub-Committee submitted no report and made no recommendations pending its assessment of the administrative impacts of the other sub-committee reports. However, the Centre concurs with the Health Services Review Committee's observation that "existing structures for dialogue, information sharing and coordination of health services (are) inadequate", and agrees that the Sub-Committee should now suggest ways to "improve the linkage between institutions, providers, community services, funding agencies and government within the context of the Health Services Review Committee's recommendations and report".

In the Sub-committee's future deliberations, the Centre urges adoption of a definition of "administrative impacts" broad enough to generate recommendations in a variety of areas. The Centre would specifically urge review of the following:

1. Information systems to support health care planning. There is a need for more coordinated development of financial systems, management information systems and computer applications, and a related need for high quality data to permit, for example, valid comparisons between institutions.

2. Linkages between Manitoba Health and the Manitoba Health Services Commission. Efforts to achieve more integrated delivery of institutional, medical and community services should entail review of existing bureaucratic structures with a view to enhancing intra-governmental linkages in health care planning and management.

3. Funding mechanisms with incentives to efficiency. Many hospitals are penalized under the current system when a more efficient utilization practice tends to increase workload and patient acuity, but involves no budgetary increase. Moreover, under present arrangements there is little incentive to seriously consider alternative methods of service delivery. Mechanisms need to be developed wherein hospitals may

relate to the MHSC on a more meaningful and regular basis concerning performance to budget, workload increases, and the impact of technological advances.

4. Mechanisms for coordination and planning of services among urban facilities, especially the tertiary care hospitals. The experience of the Health Sciences Centre with recent efforts to comprehensively plan for delivery of services through various provincial advisory committees has not been entirely satisfactory. Continued confidence in the planning process specific to these advisory committees will require the Manitoba Health Services Commission to assume more of a leadership role.

5. Medical staff involvement. Recognizing the current environment of increased regulation, advanced technology, limited funds, enhanced accountability and an aging population, innovative ways of involving the medical staff in decision making at the institutional and policy setting levels must be found. It has been estimated that physicians generate 70% of hospital costs directly by the orders they write and yet they are not placed in a position of responsibility or accountability for controlling these costs. Their lack of direct involvement handicaps any effort to internally reallocate resources to higher priority areas. Hospitals of the future must respond to the challenge and structure their organizations in ways to meaningfully involve the medical staff. This matter should be discussed by the administrative impacts sub-committee.

Sub-Committee on Cardiovascular Disorders

The HSC agrees with recommendations to expand ambulatory diagnostic facilities and not-for-admission surgical facilities in support of cardiovascular disorders. The view is held that much more cardiac investigative work (cardiac catheterization and angiography) could be done on an ambulatory basis. The Centre also suggests that in addition to expansion of day surgery services, consideration be given to establishment of graded short-stay surgical programs (i.e., 24 hour, 48 hour, 72 hour controlled admission surgical programs).

The Centre agrees with the recommendation regarding the establishment of pre-admission clinics. Such clinics have significant potential to shorten lengths of stay and produce complete and accurate pre-admission information to ensure a subsequently high standard of care and communication.

The Centre concurs that cardiac diagnostic ultra-sound and nuclear imaging procedures should continue to function "as per present arrangements", but would emphasize that adequate funding must be provided in relation to work-load

so that timely responses are made to the needs of patients and referring physicians.

The Centre agrees with the Sub-Committee that "it is essential to continue to maintain high calibre nursing service in all areas related to cardiac care", but strongly believes that the Sub-Committee underestimates the challenge in educating nurses to function in expanded roles in cardiac care. Existing hospital-based programs to prepare nurses to function as "nurse clinicians" need to be academically strengthened through formal cooperation with universities. The Centre acknowledges the potential for nurses with the requisite specialty training to function effectively in an expanded clinical role, but stresses the need for a wider professional consensus on the definition of that role. Accordingly, the Centre urges that the medical and nursing professions jointly develop standard qualifications for nursing personnel to serve as "nurse clinicians" in cardiac care. This is essential both to the coherent development of the specialty training programs for nurses and to the effective utilization of such nurses in expanded roles.

Sub-Committee on Continuing Care

The Health Sciences Centre supports the recommendations made by the Sub-Committee on Continuing Care. The Centre is particularly supportive of the recommendation to establish a Conjoint Planning Committee with a mandate to achieve integrated planning of services in the community and institutional sectors, to review and assess proposals for developing services, and to monitor and review programs. Having, as recommended, representatives from hospitals, the Continuing Care Program, the MHSC, Manitoba Health, and the community-at-large, such a standing committee would have significant potential for developing the cooperative policies and practices that are necessary to reduce existing fragmentation and ensure more continuous care of patients across various settings.

The Centre is also strongly supportive of the recommendation to increase the number of convalescent beds and long-term hospital beds for patients requiring very heavy or specialized care. Related to this, the Centre urges the M.H.S.C. to act upon the special report recommending establishment of support services for the young disabled. Acute care hospitals are currently providing long-term care to many young disabled patients who inappropriately occupy rehabilitation and neurology/neurosurgery beds. The acute care environment is not conducive to meeting the needs of these patients.

The Centre agrees that the Continuing Care Program should have the budgetary flexibility to respond to short-term variations in service demands. The establishment of an annual global budget for the program might well provide the requisite flexibility, as concluded by the Health Services Review Committee.

July 21, 1986

Sub-Committee on Critical Care

The HSC agrees with the major recommendations of the Sub-Committee on Critical Care. The HSC supports the recommendation concerning more effective utilization of critical care units. This will require a broad approach aimed at more effective use of emergency departments and all in-patient beds. The development of intermediate care units or so-called "step-down" beds is a promising component of this overall approach. Critical care units with appropriate policies and procedures, admission and discharge criteria, and overall management by clinical directors is strongly recommended by the Centre.

The Centre also supports improved cooperation between all critical care units in the community through unit directors. It also supports the concept of improved coordination between critical care units in each facility through the establishment of critical care coordinating mechanisms within hospitals. It should be emphasized that the appropriate utilization of critical care units thoughout Winnipeg relates very much to the need for a wider rationalization of hospital roles and service capabilities.

The Centre supports the recommendation that professional associations develop standard qualifications for both medical and nursing personnel to serve in critical care units, but would caution and emphasize that these efforts must precede any move to substitute nurses for physicians in critical care delivery. With respect to the related recommendation that existing physician shortages should be eliminated with increased training of intensive care nurses, the Centre would caution that special efforts will have to be made in nursing education to effectively implement this recommendation.

Sub-Committee on Health Services for the Elderly

The HSC endorses the Sub-Committee's theme of "supported independence" and supports the associated recommendations aimed at improving both institutionally based and community based services for the elderly. The Centre concurs that geriatric assessment and consultation be optimally used to guide subsequent management and reduce inappropriate use of institutional facilities. However, the Centre would welcome a fuller analysis of the needs for in-patient assessment and treatment units and day hospital capacity in Winnipeg than has been conducted to-date.

The Centre would emphasize the need for a coordinated, comprehensive approach featuring multi-level geriatric services and graded programs. Included would be social day care, day hospitals for assessment and treatment, in-patient assessment and treatment units attached to acute hospitals and home support programs. Special programs for the

confused elderly (psychogeriatrics) are also required. The Centre believes that day hospitals should be strategically located in close association with in-patient assessment and treatment units at most acute hospitals.

The Centre endorses the inter-disciplinary approach to the care of the elderly and the importance of recruiting an adequate number of physicians trained in geriatric medicine to provide support for these programs. In this connection, the Centre would suggest that consideration be given to establishing a Gerontology Institute at one of the major hospitals to provide information and promote inter-disciplinary teaching and research on aging complementary to the activities of the Centre on Aging at the University of Manitoba.

The Health Sciences Centre is concerned about the long-term care of elderly patients in the acute hospital. An element of neglect may be associated with their care when their prospects for recovery and reactivation are much poorer than the other acutely ill patients with whom they are mixed. It is important therefore that special provision be made for the care of the elderly in the acute facility. Programs emphasizing reactivation and rehabilitation should be encouraged and supported. As well, there is little doubt that more and better cooperation between all institutions and agencies would do much to enhance the care of the elderly.

Sub-Committee on Emergency Health Care

The Health Sciences Centre concurs with the Sub-Committees's statement of major problem areas in emergency health care and agrees with the recommended solutions. Related matters that the Centre judges important and warranting serious attention include:

1. The relatively low level of remuneration for emergency room physicians. Remuneration of ER physicians in Manitoba is among the lowest in Canada and is resulting in losses of highly qualified individuals to other jurisdictions. This has significant implications for the quality of emergency care in the province.

2. Disaster planning. The Health Sciences Centre is aware that previous activity has been undertaken with respect to the development of a comprehensive area-wide disaster plan for the city of Winnipeg. Such a plan should involve all agencies, transport systems, police, fire, health care agencies and home care. The military and civil defense might also be involved. It is suggested that there should be a designated person in authority with the appropriate staff and community support to assume the responsibility for coordinating area-wide disaster planning.

3. Trauma centers. The Center recommends that the roles of the various hospitals within the health care system should be defined with respect to trauma services. These roles should be communicated to all transport agencies involved in emergency medical services to ensure appropriate coordination and utilization of the system.

Sub-Committee on Gastrointestinal Disorders

The HSC supports the recommendations made by the Sub-Committee on Gastrointestinal Disorders. However, there are three important issues related to gastroenterology that were not addressed in the report. First, there is a shortage of gastroenterologists in the community. Second, there is no effective provincial program specific to gastrointestinal disorders; the Centre would urge that the necessary planning efforts be initiated. Third, and related to this, the Centre identifies a need for sophisticated imaging services on a scale beyond that recognized in recent recommendations of the CT Advisory Committee. Accordingly, the Centre recommends that further, more systematic planning for sophisticated imaging services be undertaken.

Sub-Committee on Indian Health Care

The Health Sciences Center supports the recommendations of the Sub-Committee on Indian Health Care. The Center is a unique institution in terms of the range and scale of health care provided to the native population, and is especially cognizant of the special and growing needs of this population. Indeed, in a recent, formal restatement of its overall mission, the Center strengthened its commitment to respond to the health care needs of natives and Winnipeg's core area population. Further, the Center is currently considering several organizational initiatives that would directly serve the interests of natives and enhance their access to necessary health services.

Sub-Committee on Not For Admission (NFA) Surgery

The Health Sciences Centre suuports the recommendations of the Sub-Committee on NFA surgery. The Centre recognizes that significant potential exists for increasing the proportion of surgery performed on a day basis, particularly in the adult area. There are a number of patients at the Center who occupy beds whose needs would be better served through the expansion of a day surgery program. In general terms, any major facility should perform at least 30% of its total surgical volume on a day care basis. In fact, some centres reach or exceed a figure of 40%.

The Health Sciences Center would also emphasize the importance of developing graded short-stay programs involving twenty-four hour, forty-eight hour, and seventy-two hour surgical stays. It is possible to organize the allocation of beds to permit better control and more effective utilization. In the future, the Centre is interested in the possibility of converting the Women's Hospital into a short-stay surgical facility.

The Health Sciences Centre would stress the importance of expanding the volume of general medical procedures performed on a day basis. Included here are cardiac catheterization and coronary angiography, blood transfusions, chemotherapy, and other medical day treatments that need not involve in-patient care.

Expansion of day care surgery, day care medicine, and short-stay surgical programs will require other compensating adjustments in home care and other community based programs to maintain appropriate standards of care.

Sub-Committee on Obstetrics

The Health Sciences Centre agrees with most of the recommendations of the Sub-Committee on Obstetrics. However, the Centre would emphasize the need for the establishment of a coordinated perinatal network in the province of Manitoba. An organized provincial perinatal program should involve:

(1) the recruitment of a neonatologist to head the section of neonatology at the University of Manitoba and to serve as Chairman of the provincial perinatal program; (2) the establishment of a central secretariat to support the overall activities of the program; and (3) the clear delineation of roles and responsibilities of various hospitals (obstetrics and neonatal services with respect to perinatal care), consistent with a regionalized program for obstetrics and neonatal care.

The Centre expresses concern with the Sub-committee's recommendation that "because of the acute manpower shortage in the neonatal intensive care nurseries, a neonatal nurse clinician training program should be set up immediately". As earlier noted and emphasized, the Centre believes that the medical and nursing professions must jointly agree on standard qualifications for nurses in expanded clinical roles before training programs are mounted. As well, it strongly believes these training programs should be academically rigorous and university based.

Sub-Committee on Oncology

The HSC agrees with recommendations of the Sub-Committee on Oncology relating to the establishment of a central registry of oncology patients, the support of

primary and secondary prevention efforts, the expansion of ambulatory care and NFA surgery, and the development of a province-wide program in oncology. In respect of the latter, the Centre would urge further review of needs and programmatic requirements in areas outside Winnipeg and the immediate catchment area of the Manitoba Cancer Treatment and Research Foundation. The advantages and disadvantages of a large centralized facility should be very carefully assessed. The treatment of cancer patients requires the services of a large number of health professionals and support systems and the HSC would hope that a province-wide program would acknowledge this requirement in the specifics of service organization and delivery.

The HSC believes that the roles of various hospitals vis-a-vis oncology should be more clearly specified. On review, some aspects of oncology might warrant greater centralization, while others may not. The HSC supports the establishment of geographic in-patient oncology units as recommended by the Sub-committee. However, the establishment of dedicated units within an expanded MCTRF is a proposal that needs very careful evaluation. The HSC is not convinced that better care could be provided to oncology patients by locating them in a new unit on top of the MCTRF. Indeed, staff of the HSC have concerns that such relocation would adversely affect the quality of patient care. Within the Centre progress has been made in establishing a dedicated medical oncology unit on ward D6 (20 beds). The centre is currently preparing the architectural program for that unit and construction should be complete some time in mid-1987.

The HSC is currently addressing the adequacy of current hostel facilities in relation to present and future demands of patients who have needs in this area.

Sub-Committee on Outpatients

The Health Sciences Centre agrees with most of the recommendations of the Sub-Committee on Out-Patients. The Centre strongly supports the recognition of ambulatory care in the organizational structure of hospitals. One model being considered by the Centre would involve establishing an inter-departmental, inter-disciplinary Division of Ambulatory Care with a clinical director and central administrative support.

The Health Sciences Center also strongly endorses the concept of integrating ambulatory programs with in-patient programs and community based services to achieve continuity of care. The Centre views the trend toward ambulatory care in tertiary centers not simply as office based practice in a hospital setting, but as programs serving a clientele with complex, multi-system problems requiring secondary and tertiary care closely linked to in-patient programs. If ambulatory care is to provide an effective alternative to in-patient care, then this degree of integration becomes

extremely important and hospital based ambulatory care becomes more specialized than that associated with private office practice.

In the opinion of the Health Sciences Centre, the entire question of charging overhead in an ambulatory care setting has to be approached very carefully. With major changes occuring in ambulatory care involving integration with in-patient care and greater dependence on hospital resources, the analogy to private office practice is inappropriate. Thus, policies concerning overhead charges have to be very carefully developed.

To prepare physicians and other health professionals for the future, it is also very important to make adequate provision for clinical education within the ambulatory setting.

Sub-Committee on Pediatrics

The Health Sciences Center agrees with the majority of the recommendations made by the Sub-Committee on Pediatrics. Specifically, the Health Sciences Center strongly agrees that there should be only one pediatric intensive care unit within Winnipeg and that this should be located at the Children's Hospital. With respect to the consolidation of neonatal intensive care units, the view is held by the Health Sciences Center that two units are justified within the Winnipeg area. As noted earlier, the Centre recommends establishment of a provincial perinatal program.

The Centre also supports recommendations concerning expansion of rehabilitation services for the young disabled and pediatric rehabilitation services in the areas of physiotherapy, occupational therapy, and speech therapy.

Sub-Committee on Respiratory Disorders

The Health Sciences Centre supports many of the recommendations concerned with respiratory disorders. The Centre agrees with the Sub-Committee that there is no rational reason for patients on long-term oxygen therapy to be denied admission to personal care homes. While it may be difficult to provide oxygen therapy in personal care homes with existing staffing and resources, this service could be effectively provided on the same basis as is now the case for home oxygen therapy, i.e., under the provincial home care program.

The Centre strongly supports the development of graded programs for respiratory care involving acute and chronic care in various settings (municipal hospitals, personal care homes, community). There must be careful linking of all programs to reduce the possibility of any barriers to the effective delivery of care and the movement of patients between the various care levels and service settings.

Sub-Committee on the Terminally Ill

The Health Sciences Center agrees with the majority of the recommendations of the Sub-committee on the care of the terminally ill. It does not fully agreee, however, with the recommendation to establish a number of palliative care units on a geographic basis within facilities. An alternative approach worth considering would involve a palliative care outreach team consisting of a physician, nurse, social worker and possibly others who would provide consultation, education, and general support to all other nursing units responsible for the care of the dying. The Centre certainly supports the idea of a model program for the community. Such a program could provide health professionals with the opportunity to develop appropriate skills and attitudes and, as well, provide outreach to all other units.

With respect to patients' rights, the Centre suggests that health care facilities consider establishing multi-disciplinary ethics committees. Such committees would provide advice and consultation, as well as develop guidelines concerning the care of patients. Many health care professionals might welcome guidance and support in making ethical decisions. It should be emphasized that ethics committees should not assume the decision-making functions of the physician or other health care professionals.

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86 06 13

Mr. David Pascoe
Chairman
Health Services Review Committee
308 - 294 Portage Avenue
Winnipeg, Manitoba
R3C 0P9

Dear Mr. Pascoe:

In answer to Mr. Desjardins' letter of February 1986 and your letter of May 12, 1986 inviting response to the Health Services Review Committee's report, I am pleased to forward to you the enclosed brief. We trust that our statement will be found informative, helpful and positive.

Sincerely yours,

F. P. Doyle, M.D.
Chairman
Board of Directors

FPD:sjs

Enclosure

cc The Honorable L. L. Desjardins
Mr. L. A. Quaglia
Mr. G. Holland
Mr. J. Lozon

86 06 13

Response to the Report of the Manitoba Health Services Review Committee

Since 1957, when Canada introduced a hospital insurance scheme, and subsequently in 1966 when it added medical services to insured services, there has been produced a vast metamorphosis in health care in our country. Today, virtually every citizen is insured against the cost of health needs. This has resulted in the permanent establishment of a key element of Canada's social security safety net, but it also has contributed to the relatively rapidly increasing costs. Governments, as a consequence, have developed fears that they may be unable to fund and sustain the present health care system. Growing expenditures have forced all interested segments of the health field to seek ways of improving the efficiency and effectiveness of the delivery of health care.

Although Canada's health care system faces severe challenges, it should be noted that many of the problems that we confront are directly related to the considerable achievements that have been made. Most importantly, no Canadian family now faces the unacceptable alternative of either receiving care and in so doing bear crushing bills, or doing without care altogether for the sole reason that it cannot bear the cost of service. While there is virtual unanimity in our nation that nothing must jeopardize this vital accomplishment, it is equally clear that comprehensive health care coverage places a heavy burden on the financial resources of Canada.

In addition to ready availability of, and accessibility to basic services, patients look to better and more extensive methodologies of care and of treatment. Physicians have become more specialized and more responsive to their needs. Nurses have become better educated and more specialized in health delivery. Hospitals have responded to changing needs by offering more effective and sophisticated care and high risk referral centres. Obstetrics has improved remarkably. Fetal care of neonates that at an early day would have been impossible has become common and routine. Heart operations, such as coronary by-pass, have become frequent. Neurosurgery, general surgery, medicine, and in fact all disciplines have become highly sophisticated, with an increasing need for more costly diagnostic procedures including new laboratory techniques, radiology, ultrasound, C.T. Scanning and N.M.R. Scanning. Against this background of accomplishment, it also is clear that persistent and difficult problems have arisen within the health care delivery system. Across the nation, over and above the treatment of more common cases and less ill patients, many if not all tertiary and many principal hospitals are finding it increasingly difficult to cope with a growing need for care of the far more seriously ill patients because of the limitation of resources and the rising need for more adequate technological aids for diagnosis. This situation has developed because the advances in health care have raised new hope and higher expectations for treatment of hitherto untreatable trauma or of incurable disease, as well as the changing severity of illnesses developed by patients in an aging population.

Emergency units in tertiary and urban hospitals are often overcrowded and overextended with increasingly ill patients. A factor contributing to this dilemma is that a large percentage of active treatment beds in tertiary and principle urban hospitals are filled with patients, who, having been treated

for their acute illnesses, may not be able to return home, hence, they become long stay cases awaiting placement in alternate facilities.

In view of these considerations, we commend the Department of Health of the Province for initiating a far ranging and comprehensive review of the health services delivery system in Manitoba. In assessing the recommendations and conclusions of the Health Services Review Committee, we would urge that immediate and urgent action be taken in the following areas:

1. The needs of tertiary and teaching facilities require immediate and special attention. Deficiencies in tertiary or higher risk acute care resources must be corrected and could be reduced in very large part by developing a greater appreciation of the needs of long stay patients and by developing sufficient nursing home beds, as well as by considering the establishment of more elderly housing units. Hotel-hostel-nursing units near tertiary centres could reduce the pressure on acute care beds while allowing for out-patient diagnosis and treatment as well as facilitating the transfer of patients in time of need.

2. An increase in the availability of tertiary acute care beds is urgently required not only to provide better service, but service appropriate to the changing needs, and also for improved teaching. Certain specialties such as ophthalmology and orthopedics require special consideration and development. High standard accredited teaching is essential to meet the health care challenges of today. Furthermore, there must be an adequate development of diagnostic services as well as the services herein mentioned.

3. Out-patient and outreach services must be closely studied. Government, the nursing profession and the medical profession should help in assessing needs. It must be understood that some services may not be required, while others may demand further development. It is important to ensure that programs and facilities are being used both appropriately and for their intended purposes. Steps must be taken to ensure that patients do not remain in inappropriate in-patient facilities whether the latter be acute beds or nursing home beds.

4. Improvement must be made in the efficient use of facilities, including improved practices in pre-admission investigation, early discharge, not-for-admission surgery, etc.

5. Changes in the use of some acute rural hospital beds may be required as some rural hospitals have under utilized facilities. On the other hand, there may be justification for the development of additional secondary care hospital units in rural areas with the active recruitment of specialists to supplement the work of family physicians in these units. This approach could reduce the pressure presently on urban referral hospitals and may be more appropriate to the needs of rural people.

These are the areas which we consider to be those requiring pressing attention. However, we have considered with interest many of the specific recommendations of the Review Committee. While we can endorse the further examination of these matters, we contend that improvements in service and the

correction of significant deficiencies in the system will be found in the pursuit of the major areas of concern noted above.

The Health Services Review Committee has identified a rising demand for a limited supply of acute health services. To meet the problem, the Committee proposes not to increase the supply but to direct demand by providing alternate supply sources and to ration supply by making choice more difficult through the application of the theory that duplication is both wasteful and economically inefficient. This assumption is only partly correct, in fact competition is frequently conducive not only to improving service and standards but to the reduction of costs. Alternative services will be economically effective only if the services are indeed of value to the system and only if the services can be provided less expensively than in hospital. Services such as stress testing, N.F.A. surgery on weekends, may indeed be less expensive when performed in hospital.

Centralization has advantages such as in offering care in high risk obstetrics in two or three hospitals. But this does not mean to say that all obstetrics in other hospitals should be discontinued. We believe that centralization of obstetrics in metropolitan Winnipeg has proceeded far enough. There is not only place, but need, for obstetric services in hospitals such as the Misericordia, the Grace and the Victoria. Care should be taken particularly in rural areas in the contemplation of the centralization of obstetric services. Nor should there necessarily be only one neonatal intensive care centre or pediatric heart surgical centre. Good service, high standards, good quality and care, competition based on quality care and costs, freedom of choice, should be determining factors, in addition to cost, and sometimes more importantly than cost.

The St. Boniface General Hospital exists not only to serve people but to offer a choice to people.

Decisions concerning life prolonging means should rest with the patient on sound advice, and not simply through appointed committees.

The statement that there should be no construction of more nursing home beds is at least debatable on the basis of the information presented.

With respect to suggestions that innovative programs must be integrated with continuing care, we point out that at present continuing care is entirely government operated and engages only University nurses. We think there should be room for voluntary agencies. Furthermore, savings will be effected only if care is given by appropriately prepared persons.

We note in addition that many of the Committee's recommendations refer questions and concerns to third parties. It views such references with some degree of apprehension and concern given the magnitude and urgency of the issues facing the health care delivery system in Manitoba and given the rights of individual patients. Such references, in the absence of clear and unequivocal leadership and direction, have the potential of creating unwarranted and harmful delays in implementing much needed remedies and reforms, but more importantly may lead to activities which are costly, without necessarily assuring quality care.

Although a number of the recommendations in the Report are not acceptable, many if not all should be given thorough consideration. Manitoba's health care system is characterized by the participation of both the public and private sectors, and it works best when government, the professions, and the institutions work together to implement change.

In developing our health care system in response to identified patient needs by assuring the adequacy of diagnostic technological and treatment modalities, and while being assured of the greatest efficiency of operation, care must be taken lest the patient become a commodity rather than a person. In assuring the most rapid throughput, the earliest discharge, the greatest preoperative out-patient work-up or the most suitable "on paper" disposal, we must not forget the existence of the total patient who has a heart, a mind, and a spiritual entity as well as the right to choice. These factors may belie the most scientifically oriented or categorized assumptions. In our view there must remain in our health care system that essential element called "caring".

F. P. Doyle, M.D.
Chairman of the Board
St. Boniface General Hospital

FPD:sjs

cc The Honorable L. L. Desjardins
Mr. L. A. Quaglia
Mr. G. Holland
Mr. J. Lozon

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afm

Inter-Office Memorandum

Date: May 6, 1986

To: T. R. Edwards, C.A.
Deputy Minister
Manitoba Health

From: Ian J. Puchlik
Acting Executive Director

Subject: **HEALTH SERVICES REVIEW COMMITTEE REPORT**

You will recall that David Pascoe made a presentation on the Report to the Foundation's February 1986 Planning Seminar. Alcoholism Foundation of Manitoba staff have also completed an assessment of the implications for this organization which has been presented to the Board of Governors to highlight the findings of the Committee and those aspects of the Review which are relevant to the AFM.

I am bringing this to your attention at this time since many of the recommendations have direct implications for the AFM. Accordingly, I am interested in learning the status of the disposition of the Report recommendations outlined in the attachment to this memo, and in registering the Foundation's interest in being kept informed of developments or being involved in any discussions toward the resolution and improvement of relevant items identified by the Review, as appropriate. In addition, the Foundation is interested in opportunities to access demonstration project funds recommended for reallocation by the Review.

/chh

REPORT OF THE HEALTH SERVICES REVIEW COMMITTEE
SUB-COMMITTEE RECOMMENDATIONS RELEVANT TO THE ALCOHOLISM FOUNDATION OF MANITOBA

1. SUB-COMMITTEE ON INDIAN HEALTH CARE

(a) Transfer of Responsibility

Manitoba, Canada and Indian organizations should jointly establish a mechanism for the transfer of health services delivery to local control.

Disposition: To be recommended to the Deputy Minister of Health to convene a meeting of the three parties.

Prior to the transfer of health services delivery to local control, senior administrative levels of both governments and Indian organizations should develop interim measures for cooperation.

Disposition: To be referred to the Deputy Minister of Health.

Implications for the AFM:

It is assumed that alcohol and drug services would be included as a component of health services considered for transfer of responsibility to Native control. Because such transfer would have an impact on current AFM program operations and fiscal resources, as well as on its role as funder of external Native agencies, the Foundation should be involved in any discussions surrounding responsibility transfer.

(b) Federal/Provincial Jurisdictional Responsibility

The federal and provincial governments should meet quickly to review, evaluate and renegotiate the 1964 memorandum of agreement between Manitoba and Canada regarding the quid pro quo of shared services in different geographic areas of the province.

Disposition: To be referred to the Minister of Health.

The provision of uninsured services for Status Indians requires clarification (eg. home care services, medical equipment, alcohol and drug treatment, personal care home eligibility, rehabilitation for the physically disabled).

Disposition: To be referred to MHSC, Manitoba Health and federal Medical Services Branch.

Implications for the AFM:

The 1964 agreement between Health and Welfare Canada and the Manitoba Department of Health outlines jurisdictional responsibility for health service, funding and staff to Status and non-Status Native communities in Manitoba. In effect, the agreement designates communities where a majority of the population is Status Indian to Federal jurisdiction for the provision of clinical and community health services. AFM participation in the renegotiation process might provide an avenue for resolving AFM and NNADAP responsibilities.

Similarly, AFM participation to clarify the delivery of alcohol and drug treatment as an uninsured service should be pursued.

(c) Tripartite Committee

A tripartite committee should be established to make recommendations and decisions at senior levels to deal with health and health-related matters of Indian communities.

Disposition: Health Services Review Committee concurs in the establishment of a tripartite committee.

A planning process should be developed to direct the ongoing development, coordination and operation of health services in rural and northern areas as it impacts on populations of special risk (eg. Indians and the elderly).

Disposition: To be referred to tripartite committee when established.

Joint endeavours such as common environmental services, shared training and orientation programs for health personnel and health deomonstration projects should be considered for implementation.

Disposition: To be referred to tripartite committee when established.

Implications for the AFM:

Given the impact of alcohol and drug abuse on Native health care status, the AFM's participation in the deliberations of a tripartite committee would insure Foundation input to and influence on, decisions related to addiction programming. AFM representation would also increase the Foundation's information base on federal, provincial and Native health services initiatives, and may provide opportunities for projects to be undertaken jointly with other organizations.

(d) **Training**

The federal and provincial governments should seek ways to increase training opportunities to enable Indians to assume responsibilities as program planners, health professionals and para-professionals.

Disposition: To be recommended to the governments of Manitoba and Canada.

Indians and Inuit should be involved with the provincial and federal governments in setting priorities for Native health-related training programs.

Disposition: To be referred to tripartite committee when established.

Implications for the AFM:

Since the AFM is currently involved in the delivery of Native training programs, the Foundation would seem to be an appropriate Manitoba resource for initiatives undertaken in response to this recommendation. However, such initiatives would require due consideration of available AFM resources.

(e) **Research**

Besides medical intervention methods, future Indian health planning and research should include environmental, educational, lifestyle and socio-cultural factors.

Disposition: To be referred to tripartite committee when established.

Through the tripartite committee, Indian involvement and participation in research and evaluation activities for Indian communities should be encouraged.

Disposition: To be referred to tripartite committee when established.

Funding agencies should be requested to identify specific funds available for research related to Indian health care and involve Indians in the allocation of these funds.

Disposition: To be referred to research funding agencies.

A survey of the Native population in Manitoba's urban centres should be undertaken to determine the impact of migration on health care utilization.

Disposition: To be referred to the Winnipeg Social Planning Council.

Implications for the AFM:

The Foundation is currently developing its research capacity. Access to research funds and project results as well as opportunities to further the AFM's research capability would be beneficial for program and policy planning and development. Consultation and participation in initiatives undertaken if these recommendations are addressed should be pursued.

(f) Information Systems

Statistics of a health information system should be made available in a public document on an annual basis.

Disposition: To be referred to MHSC.

An improved information system should be developed to ensure that accurate, timely and complete health status and health care data are available by age, sex, residence, community and region, cross-indexed to relevant indicators.

Disposition: To be referred to MHSC.

Implications for the AFM:

The Foundation is also currently developing its information system capacity. Increased access to sound health service data and assistance in system development would benefit AFM requirements in this area, and increase the Foundation's ability to analyze data to anticipate and plan for emerging trends and other impact factors.

2. **SUB-COMMITTEE ON EMERGENCY HEALTH CARE**

The Emergency Health Care Sub-Committee recommended that health promotion measures should be encouraged, such as education regarding alcohol and safe driving as well as CPR methods for the lay public.

Disposition: To be referred to Manitoba Health.

Implications for the AFM:

Since the AFM has a mandate to provide public education, information and training programs related to alcohol and other drugs, and is the primary provincial provider of DWI programming, the Foundation should participate in any health promotion activities which may arise from this recommendation, with due consideration of available resources.

3. **SUB-COMMITTEE ON RESPIRATORY DISORDERS**

The Sub-Committee recommended that effective anti-smoking advertising should be undertaken.

Disposition: To be referred to Manitoba Health.

Implications for the AFM:

The AFM should be involved in an advisory capacity to the planning, design and implementation of any campaign arising from this recommendation in cooperation with other agencies (eg. Manitoba Heart and Lung Associations).

4. **SUB-COMMITTEE ON OUT-PATIENT MEDICAL SERVICES**

The Sub-Committee recommended that Manitoba Health should make a comparison of the costs accrued to the provincial health care budget by alternative types of health services delivery and recommend the most cost-effective combination.

Disposition: Referred to the Sub-Committee on Administrative Impacts.

Implications for the AFM:

If this recommendation is accepted for development, the results of such a review would be beneficial to the Foundation as it prepares its own assessment of alternative delivery mechanisms.

5. **SUB-COMMITTEE ON PEDIATRICS**

The Sub-Committee recommended that both health professionals and the public should be made aware of the cost of the present health care system and that an assessment of the effect of public education programs on utilization should be made.

Disposition: To be referred to MHSC, MARN and MMA.

Implications for the AFM:

Similarly, if this recommendation is accepted for development, the results would benefit the AFM's own efforts to develop efficient and cost-effective information and education programs.

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
1410-155 Carlton Street
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Telephone (204) 947-1694

Address all correspondence to
the Registrar

July 3, 1986

Mr. D. Pascoe, Chairman
Health Services Review Committee
308-294 Portage Avenue
Winnipeg, Manitoba
R3C 0B9

Dear Mr. Pascoe:

Re: Health Services Review Committee Report

The Executive Committee at its most recent meeting considered your letter of May 12, 1986, soliciting responses to the report.

It was the decision of the Executive Committee that the College would not submit a response to this report.

Yours sincerely,

JAMES B. MORISON, M.D.
Registrar

JBM/ejm

Rehabilitation Centre for Children

633 WELLINGTON CRESCENT WINNIPEG, MANITOBA R3M 0A8 TELEPHONE (204) 452-4311

June 6, 1986

Mr. David Pascoe, Chairman,
Health Services Review Committee
Health Services Commission Research and Planning
308 Somerset Place
294 Portage Avenue
Winnipeg, Manitoba
R3C 0B9

Dear Mr. Pascoe;

Re: Report of the Health Services Review Committee

I have had the opportunity to review this report, with particular reference to the pediatric recommendations, both in my capacity as a member of the Pediatric Death Review Committee of the Standards Committee of the College of Physicians and Surgeons of Manitoba, and as Medical Director of the Rehabilitation Centre for Children.

Naturally, I have considerable interest in the area of pediatric rehabilitation, and concur wholeheartedly with the committee's assertion that pediatric rehabilitation services must be expanded and coordinated within the province. I have a major concern with the recommendations of the committee in this regard, and, in particular,

(1) the basing of this program at the Health Sciences Centre

(2) the recommended closure of the Rehabilitation Centre for Children.

For many years Manitoba has been a leader in Canada in providing community-based programs for the rehabilitation of handicapped children. This leadership has issued from governmental action, from community action, and from the action of private organizations. Our rehabilitation programs have always beens designed, and future programs planned, on the basis of social integration of our handicapped population, and deinstitutionalization wherever possible. The process of normalization implies that physical disabilities, in particular, not be regarded as disease entities, and not as amendable to the medical model of treatment as to the human services model. While it is true that there is a major medical input during the acute phase of many of the handicapping conditions, the longterm management of these problems necessitates a multidisciplinary approach with a heavy focus on community, social and educational aspects, and the provision of regionalized and locally

delivered support services. This philosophy is incompatible with the organization and basing of such a program at a tertiary level acute care medical institution. Although it is imperative that strong medical direction and input be afforded, the conduct and basis of this program in the hospital atmosphere is not conducive to the promotion of the normalization image for which the province has sought so diligently, and encouraged so effectively, over the past fifteen years.

The recommendation for closure of the Rehabilitation Centre for Children is particularly disturbing. The data base for this very major recommendation, as cited in the appendix to the report, appears to be solely the statistical report of the Centre. I am unaware of any organized or formal attempt of any member of the committee to obtain qualitative information from any member of the administration of the Centre, or by an onsite visit. The report emphasizes that ambulatory programs should be encouraged, and indeed this is what has occurred at the Rehabilitation Centre for Children. Clinical activity has expanded into areas of modern application of technology to the handicapped, and also in the area of general orthopedics which allows for the early identification of handicapping conditions. Furthermore, the Centre has assumed the organization and administration of the School Therapy Services Program within the Winnipeg School Division which has further enhanced the community outreach activities of the Centre, and allowed for early detection of handicapping conditions, and hopefully their early remediation. This ambulatory emphasis has been, of course, at the expense of the inpatient volume which has diminished considerably to the point where cost effectiveness has to be questioned. I would consider this direction of the Centre to be laudable.

Secondly, the Rehabilitation Centre for Children has several programs without duplicate in the entire province. The Prosthetics Program serves over 95% of all childhood amputees within the province of Manitoba, and offers a level of service with myoelectric upper limb prosthesis which is second to none in the country. The Special Devices Program and the Specialized Seating Program is held in high national regard, and provides ever-increasing service for the handicapped child-hood population of our province. This service is duplicated at no other location, and is without peer in the province in terms of its expertise. In the area of Biomedical Engineering, an exciting new field of the computer applications to handicapping conditions, and the increasing availability of communication aids, heralds a new era in the application of electronics to the physically handicapped. These programs have been established at the Centre for several years now and alternative service is available no where.

While it is true that many of the technical programs could be relocated with appropriate space, it is difficult to justify this when the Rehabilitation Centre for Children offers excellence in these programs at a location which is not directly seen as a hospital setting by the consumers of the service. The assertion that the location of the Centre is not conducive to effective delivery of programs is not substantiated by experience in other provinces where regional rehabilitation centres in close, or in more remote locations, are very active and highly successful. I would submit that part of the reason for under utilization of the Rehabilitation Centre for Children for general rehabilitation purposes has been the approved development of alternative programs at Children's Hospital, and the expansion of chronic care at that facility. It has been very encouraging to see the emphasis in pediatric care become more community oriented, outreach in focus, and comprehensive in its delivery. Whether, in the area of rehabilitation, this should be the role of an acute care tertiary hospital, is open to question.

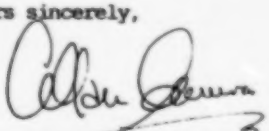
I would favour the development of a provinical program for physical rehabilitation which is comprehensive in nature and multi-disciplinary in its approach. A regionalized service would assure a community orientation. Areas of specific medical expertise should be encouraged and developed. These areas particularly exist with the prevention of handicaps as provided by improving the neonatal care situation at St. Boniface and Health Sciences Centre, and by improving the acute care facilities for children suffering from potential handicapping conditions. The delivery of a comprehensive rehabilitation program for children with residual disabilities requires a coordination with health, community services and education playing major roles. Many professional disciplines would necessarily have to be involved, including, but not restricted to, medicine, nursing, psychology, social work, education, recreation, engineering and technical specialties of various types. In addition, a heavy input from physical therapy, occupational therapy and speech pathology is mandatory on a provincial basis. The organization of this program at the governmental level is beyond my expertise, but whether that could take the form of a directorate within the Departments of Health, or Community Services or Education is not as important as the content and effective delivery of the services.

Although over the past few years the Rehabilitation Centre for Children has been increasingly restricted to providing the more highly technological aspects of rehabilitative care, it would appear that this would be a suitable location from which to direct such a comprehensive provincially-oriented program. It could provide a very important

interface between the acute care hospitals and the community at large, and, because of its particular multi-disciplincary approach to rehabilitation problems, offer a more community-oriented flavour to rehabilitation programs than the strict medical specialty model allows.

I would like to commend the committee for giving the strong emphasis it has to areas of potential handicap prevention, and to enhancing pediatric rehabilitation programs within the province. I would hope that when the implementation process is initiated that consideration be given to alternatives to the recommendations regarding the pediatric rehabilitation programs, and that a more comprehensive data base will be assembled prior to implementation being effected.

Yours sincerely,



A. I. Cameron, M.D., C.M., F.R.C.P.(C.)
Medical Director

AIC/gmw

c.c. Mr. D. W. Stewart
Dr. W. D. Bowman

Health Sciences Centre

Department of Radiology

GENERAL HOSPITAL
700 William Avenue
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Dial Direct (204) -

26 June 1986

Mr. David Pascoe
Chairman,
Health Services Review Committee
308 Somerset Place
294 Portage Avenue
Winnipeg, Manitoba
R3C 0B9

Dear Mr. Pascoe:

This letter is in response to the Health Services Review Committee's comments on the Gastrointestinal Subcommittee recommendations. The Subcommittee recommended strongly the expansion of ultrasound facilities. This recommendation was a unanimous decision by the Gastrointestinal Subcommittee. Our Committee used figures from the Health Sciences Centre, Winnipeg Clinic, Manitoba Clinic, and Medical Arts Building to demonstrate that routine conventional radiographic examinations of the gastrointestinal tract are less than half the numbers that they were ten years ago. Examinations of the stomach, small bowel, colon, gallbladder, and urinary tract were shown to be uniformly less than 50% of what they were ten years ago at virtually all of the stated diagnostic units. In a similar fashion, CT and ultrasound examinations of the abdomen have increased in frequency.

These figures were obtained to demonstrate to the Commission that new diagnostic tests were not simply be added to patient investigation, but were in fact replacing older antiquated and outdated examinations. However, in spite of this, it is a well known fact that patients in Manitoba are waiting several weeks to months for routine ultrasound studies. Manitoba is one of the few provinces in Canada that does not allow ultrasound examinations to be performed in private offices. It is clear that limiting this facility to hospital settings is definitely delaying patient investigation substantially. Also, modern medical practice requires that conventional radiographic examinations be replaced by more sophisticated imaging such as ultrasound. Not allowing private practicing radiologists to practice this form of radiology in an office setting is indeed preventing them from practicing radiology as it is done in present times.

All of these above arguments made up a substantial portion of the discussions at the Gastrointestinal Subcommittee. However, the Health Services Review Committee flippantly concludes that "facilities for ultrasound testing throughout the province are adequate." This is most definitely contrary to any statements made by referring physicians, members

Mr. David Pascoe

of the Gastrointestinal Subcommittee, and the Manitoba Section of the Canadian Association of Radiologists. What in fact is the point of honest and educated individuals stating what they truly feel is necessary, when the Review Committee merely picks and chooses what they feel will fit into fiscal limitations? Perhaps, private practice ultrasound cannot presently be afforded, but our Subcommittee's recommendations can certainly not be denied or ignored.

Yours sincerely,

Howard Greenberg

H.M. Greenberg, M.D.
Member,
Gastrointestinal Subcommittee

HMG/cm

The Middlechurch Home of Winnipeg

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April 23, 1986

The Honourable L.L. Desjardins
Minister of Health
Province of Manitoba
Legislative Building
Winnipeg, Manitoba
R3C 0V8

Dear Mr. Desjardins:

At the 1986 "Manitoba Health Conference", I was a participant in a panel to discuss 'planning long term care services'. I was particularly asked to give a brief personal response to the Health Services Review Committee Report.

I am enclosing for your information, a copy of my presentation; some points of which you may wish to consider in future planning.

Yours truly,

L. D. Holgate
Executive Director

LDH/cm
Encl.
wp/Desjard4

I AM VERY PLEASED TO HAVE BEEN ASKED BY M.H.O. TO GIVE MY PERSONAL RESPONSE TO THE REPORT OF THE HEALTH SERVICES REVIEW COMMITTEE. I WILL STRESS, AS WAS STATED IN THE REPORT, THAT THE VIEWS I AM ABOUT TO EXPRESS ARE PERSONAL AND "DO NOT NECESSARILY REFLECT THE POSITION OF SPONSORING AGENCIES OR INSTITUTIONS".

I WOULD FIRST LIKE TO COMMEND THE MINISTER OF HEALTH FOR ATTEMPTING SUCH A BROAD AND MUCH NEEDED REVIEW OF OUR HEALTH SERVICE SYSTEM, AND TO EXPRESS APPRECIATION TO THE MEMBERS OF THE REVIEW COMMITTEE AND THE MEMBERS OF THE MANY SUB-COMMITTEES THAT TOOK PART IN THE REVIEW. THEIR WORK WILL BE INVALUABLE IN THE FUTURE PLANNING PROCESS.

I BELIEVE THAT THIS REPORT IS ONLY THE FIRST STEP IN A CONTINUING REVIEW THAT WILL BE REQUIRED IF WE ARE TO ENSURE A COST-EFFECTIVE HEALTH SERVICES DELIVERY SYSTEM IN MANITOBA; ONE WHICH I AM CONFIDENT, WILL CONTINUE TO BE THE MODEL FOR OTHER JURISDICTIONS.

I WILL, THEREFORE, KEEP MY COMMENTS ON SPECIFIC AREAS OF THE REPORT TO A MINIMUM AND CONCENTRATE ON THE AREAS OF "OMISSION" WHICH I CONSIDER OF VITAL IMPORTANCE TO ANY ONGOING REVIEW AND PLANNING.

I HAVE, FOR THE PURPOSES OF THIS PANEL, BROKEN MY RESPONSE INTO FOUR MAJOR AREAS.

THE FIRST AREA I WOULD LIKE TO DISCUSS IS:

I. COMMITTEE REPRESENTATION:

IT IS OF GREAT CONCERN TO ME THAT SEVERAL MAJOR COMPONENTS OF OUR HEALTH SYSTEM WERE NOT PARTICIPANTS IN THE HEALTH SERVICES REVIEW COMMITTEE, AND WERE NEITHER REPRESENTED AT ALL, OR MINIMALY REPRESENTED ON THE SUB-COMMITTEES.

THE MANITOBA HEALTH ORGANIZATIONS INC., WHICH REPRESENTS THE MAJORITY OF HEALTH INSTITUTIONS IN THIS PROVINCE, AS WELL AS OTHER AGENCIES INVOLVED IN ACUTE, LONG TERM CARE, AND COMMUNITY SERVICE --WAS NOT REPRESENTED!! OF PARTICULAR CONCERN IS THE ABSENCE OF HEALTH CARE TRUSTEES WHO ARE ULTIMATELY RESPONSIBLE FOR ALL SERVICES.

M.H.O.'S - MANITOBA LONG TERM CARE COUNCIL MEMBERS, WHO COLLECTIVELY PROVIDE ALMOST 50% OF THE INSTITUTIONAL BEDS IN THIS PROVINCE, AND MANY OF THE COMMUNITY-ORIENTED SERVICES SUCH AS: RESPITE AND ADULT DAY PROGRAMS, WERE CONSPICUOUS IN THEIR ABSENCE FROM THE REVIEW COMMITTEE AND THE SUB-COMMITTEES.

THE MANITOBA ASSOCIATION OF LICENCED PRACTICAL NURSES, AND THE REGISTERED PSYCHIATRIC NURSES ASSOCIATIONS OF MANITOBA, WHO PROVIDE ALMOST 40% OF PROFESSIONAL NURSING SERVICES IN THE PROVINCE WERE NOT REPRESENTED.

LADIES AND GENTLEMEN, I BELIEVE THAT THE EXCLUSION OF THESE GROUPS FROM THE REVIEW COMMITTEE WAS A REGRETTABLE ERROR, AND MUST BE RECTIFIED WHEN ANY RECOMMENDED FUTURE COMMITTEES OR SUB-COMMITTEES ARE ESTABLISHED, IF WE ARE TO ENSURE, AS THE REPORT STATES, AND I QUOTE IN PART -- "THAT THE MINISTER CONTINUE TO ACTIVELY SEEK THE ASSISTANCE AND COUNSEL OF THE BROADEST CONSTITUENCY WITHIN THE HEALTH CARE FIELD...."

THE SECOND AREA I WOULD LIKE TO COMMENT ON IS:

II. THE REPORT ITSELF:

LADIES AND GENTLEMEN, I TOTALLY SUPPORT THE THRUST OF THE REPORT WHICH IS: TO PROVIDE A MORE CO-ORDINATED COMPREHENSIVE APPROACH TO HEALTH CARE IN MANITOBA AND TO ENSURE ACCESS TO ACUTE; LONG TERM CARE; AND COMMUNITY SERVICES; AND EQUALLY AS IMPORTANT, TO ASSESS AND PROMOTE COST-EFFECTIVE ALTERNATIVES TO EARLY, LENGTHY, OR UNNECESSARY INSTITUTIONALIZATION. TO ACCOMPLISH THIS, HOWEVER, ONE MAJOR AREA WAS ONLY TOUCHED UPON IN THE REPORT. THAT AREA IS:

III. HEALTH MANPOWER:

AS IN ANY SERVICE INDUSTRY, OUR HUMAN RESOURCES COMPRISE THE MAJOR PORTION OF OUR HEALTH CARE EXPENDITURES. UNLESS WE CAN MAXIMIZE THE COST-EFFECTIVENESS OF THAT RESOURCE, ALL OUR EFFORTS AT COMPREHENSIVE PLANNING FOR A QUALITY, ECONOMIC, SERVICE DELIVERY SYSTEM WILL BE INEFFECTIVE.

THE REPORT, I BELIEVE, ATTEMPTED TO ADDRESS THIS ISSUE TO SOME EXTENT; BUT FELL SHORT.

THE RECOMMENDATIONS IN THE REPORT WITH RESPECT TO TRAINING AND UTILIZATION WERE IN MY INTERPRETATION, DIRECTED TOWARD OUR HIGH PROFILE PROFESSIONALS - PHYSICIANS, REGISTERED NURSES, AND SOCIAL WORKERS, THE OTHER 75% OF OUR HEALTH CARE PROVIDERS WERE FORGOTTEN. IT IS THESE OTHERS WHO PROVIDE MUCH OF THE HEALTH CARE SERVICES TO THE CITIZENS OF MANITOBA, AND WHO MUST RECEIVE AT LEAST EQUAL ATTENTION IN TRAINING AND UTILIZATION PLANNING.

LET ME GIVE YOU AN EXAMPLE --

IN A LONG TERM CARE FACILITY, THE NURSING ASSISTANT MAKES UP TWO-THIRDS OF THE NURSING COMPONENT AND HAS THE MOST CONTINUOUS, AND DIRECT INVOLVEMENT IN THE CARE OF OUR RESIDENTS; YET THEIR BASIC AND POST-BASIC TRAINING AND EDUCATIONAL OPPORTUNITIES WITH RESPECT TO GERONTOLOGY AND SKILL DEVELOPMENT, EXCEPT THROUGH FACILITY INSERVICE IS MINIMAL. THIS MUST CHANGE!

IF THIS IS TRUE IN A LONG TERM CARE FACILITY, IT ALSO MUST BE TRUE IN THE COMMUNITY SERVICE. TO MAXIMIZE THIS RESOURCE CAN ONLY ENHANCE THE COST-EFFECTIVENESS OF THESE INDIVIDUALS AND THE QUALITY OF SERVICE WE PROVIDE. PLEASE UNDERSTAND -- I SUPPORT <u>FULLY</u> THE NEED TO EXPAND THROUGH TRAINING, AND EDUCATION OF OUR PHYSICIANS, REGISTERED NURSES, AND SOCIAL WORKERS, <u>BUT</u>, IF WE ARE TO PROVIDE COST-EFFECTIVE SERVICE IN OUR INDUSTRY, WE MUST ALSO DEVELOP AND EXPAND THROUGH TRAINING AND EDUCATION, OUR OTHER HEALTH CARE PROFESSIONALS, LPN'S, RPN'S, AND PARA-PROFESSIONALS SUCH AS THE NURSING ASSISTANTS, AND COMMUNITY HEALTH WORKERS. THIS COULD WELL BE ACCOMPLISHED THROUGH OUR COMMUNITY COLLEGES, AND OTHER EDUCATIONAL FACILITIES WITH APPROPRIATE PLANNING AND FUNDING. ANY DOLLAR INVESTMENT IN THIS AREA COULD REAP GREAT FUTURE BENEFITS, BOTH IN ECONOMICS AND QUALITY CARE.

IV. THE LAST, AND CERTAINLY NOT LEAST IMPORTANT AREA I WOULD LIKE TO MENTION IS <u>INSTITUTIONAL LONG TERM CARE</u>. THE LITTLE ATTENTION PAID TO PERSONAL CARE HOMES IN THE REPORT EITHER MEANS: WE ARE DOING A "HELL OF A JOB" <u>OR</u>, WE OCCUPY A LOWER PROFILE IN THE OVERALL SYSTEM. BEING AN OPTOMIST, I WILL ACCEPT THE FIRST OPTION.

THERE ARE, HOWEVER, OMISSIONS AND CONCERNS WITH RESPECT TO INSTITUTIONAL LONG TERM CARE WHICH WERE NOT SUFFICIENTLY ADDRESSED IN THE REPORT, AND WHICH I HOPE WILL BE CLEARLY STATED IN THE RESPONSE FROM M.H.O. TO THE MINISTER. THIS AREA MAY WELL WARRANT THE ESTABLISHMENT OF A SPECIAL 'REVIEW COMMITTEE'.

V. I WOULD LIKE TO CLOSE BY PROVIDING THREE RECOMMENDATIONS OF MY OWN FOR THE MINISTER'S CONSIDERATION:

1) THAT THE RECOMMENDATION TO ESTABLISH A CO-JOINT PLANNING COMMITTEE BE IMPLIMENTED; BUT, THAT THE COMMITTEE INCLUDE ADMINISTRATION AND TRUSTEE REPRESENTATION FROM M.H.O.'S MANITOBA LONG TERM CARE COUNCIL, APPOINTED BY M.H.O., IN ADDITION TO THE MEMBERS ALREADY MENTIONED IN THE REPORT.

2) THAT A SUB-COMMITTEE BE ESTABLISHED ON "HEALTH MANPOWER" WITH REPRESENTATION OF ACUTE AND LONG TERM CARE TRUSTEES AND ADMINISTRATORS APPOINTED BY M.H.O., AND REPRESENTATIVES FROM THE PREDOMINANT HEALTH CARE PROFESSIONAL BODIES, AND PARA-PROFESSIONS; M.H.S.C.; MANITOBA HEALTH; UNIVERSITIES; COMMUNITY COLLEGES; AND THE PUBLIC AT LARGE - WITH A VIEW TO PROVIDING THE CO-JOINT PLANNING COMMITTEE AND THE MINISTER, CLEAR RECOMMENDATIONS WITH RESPECT TO: BASIC AND POST-BASIC EDUCATION - TRAINING AND COST-EFFECTIVE UTILIZATION OF ALL OUR HEALTH MANPOWER RESOURCES. THIS COMMITTEE SHOULD ALSO CAREFULLY CONSIDER THE 1983 REPORT OF THE MENTAL HEALTH WORKING GROUP, THE 1985 REPORT OF THE NURSING REVIEW COMMITTEE; AND TRAINING PROGRAMS SUCH AS THE 'CORE AREA INITIATIVE GERONTOLOGY WORKER TRAINING PROGRAM'; WITH CONSIDERATION FOR EXPANSION, OR MODIFICATION FOR OTHER APPLICATIONS.

3) THAT A SUB-COMMITTEE ON INSTITUTIONAL LONG TERM CARE BE ESTABLISHED, WITH ADMINISTRATIVE AND TRUSTEE REPRESENTATION FROM M.H.O.'S MANITOBA LONG TERM CARE COUNCIL, ACUTE CARE, M.H.S.C., MANITOBA HEALTH, AND THE PUBLIC AT LARGE.

THIS COMMITTEE SHOULD REVIEW THE TOTAL PERSONAL CARE HOME PROGRAM INCLUDING PERTINENT LEGISLATION WHICH CURRENTLY MAY IMPEDE THE FLEXIBILITY OF PROVIDING SOME INNOVATIVE SERVICE PROGRAMS IN PERSONAL CARE HOMES.

LADIES AND GENTLEMEN: THANK YOU FOR YOUR KIND ATTENTION. I WOULD BE PLEASED TO HEAR YOUR COMMENTS.

LDH/cm

wp/HsRspee3

APPENDIX C

HEALTH SERVICES REVIEW

ADMINISTRATIVE IMPACTS SUB-COMMITTEE

AUGUST, 1986

ADMINISTRATIVE IMPACTS SUB-COMMITTEE REPORT

Background:

The Report of the Health Services Review Committee recognized that the Manitoba health care system is currently functioning under considerable stress. Health care facilities appear to be operating at close to capacity, and there are continuing demands for service which have potential to tax existing resources to the limits.

While it is recognized that health care facilities fulfill a particular role, they should be adequately resourced for that purpose. A common theme emerged to investigate viable alternatives to institutional care. All sub-committees eagerly responded to the challenge and made a genuine attempt to come to grips with the problems of increased demands upon existing fiscal and health care facilities resources.

The Health Services Review Committee perceived that the Province's ability to respond to health care delivery needs in Manitoba could be directed in several ways. The alternative to "develop innovative alternatives of treatment and prevention to the present emphasis on in-patient services" was the option recommended to the Minister by the Committee.

The major impacts of change will affect the overall structure of health, care administration. The need is paramount for all components of the health care system to initiate, develop and maintain communicative and cooperative linkages to assure that the changes recommended become a reality.

Terms of Reference:

An interim report of the Administrative Impacts Sub-Committee was included in the Report of the Health Services Review Committee (Volume II, pages 8 and 9). Subsequently, the Sub-Committee was directed to examine administrative impacts upon the existing structures for information sharing and coordination among the sectors of Manitoba's health care services.

Specific objectives for the Administrative Impacts Sub-Committee included the following:

1. assessing and vetting the Administrative Impacts of the approved recommendation of the other Sub-Committees.

2. acting as a resource for explaining or clarifying the impacts of the Health Services Review Committee Report to the health care administration community of Manitoba.

Consistent with the conclusions of the Health Services Review Committee, the Sub-Committee was directed to define innovative alternatives of treatment and prevention, in contrast to the present emphasis on in-patient services.

Sub-Committee Membership:

Jack Litvack, Chairman	Urban Teaching Hospital
Ross Brown, M.D.	Urban Teaching Hospital
Roy Brown	Long Term Care Facility
Glen Chapman	Rural Hospital
Frank DeCock	Manitoba Health Services Commission
Art Hiebert	Urban Community Hospital
Jeff Lozon	Manitoba Health Organizations
Don Krack, Recording Secretary	Manitoba Health Services Commission
Sharon MacDonald, M.D.	Manitoba Health
Peter Pauls	Rural Hospital
A. Rod Thorfinnson	Urban Teaching Hospital
Betty Yallowega	Urban Community Hospital

Administrative Impacts Sub-Committee's Recommendations:

The Committee discussed a number of factors with regard to the health care administrative environment in Manitoba. The need for improved communication and collaboration between health care facilities, health care agencies and community health was reviewed. Development of a pro-active, innovative approach by health care administrators to the challenges confronting Manitoba's health care system was also reviewed in detail.

The Committee considered the potential of a series of options such as prospective payment systems and use of diagnostic related groups (DRG's) for the administrative structure of health care facilities and agencies in the Province. It was agreed that no single model could be applied to the health care facilities and agencies in the Province of Manitoba as their structure, size, role and function required the development of specific tailoring to each individual facility or

agency. There was general consensus, however, that there was an overall need for facilities and agencies to review their structure and methodology of management to assure that they are providing a leadership base consistent with the corporate needs of that particular facility or agency.

After review of the many recommendations of the other sub-committees regarding administrative topics, the Administrative Sub-Committee attempted to define reoccurring themes and significant principles to facilitate the change process recommended by the Health Services Review Committee. The Sub-Committee defined several enabling factors which will be required to facilitate the desired change. It was assumed that the change process would be a collaborative effort between government and health services providers. The Sub-Committee avoided any prescriptive approach which would apply specific constraints upon individual health facilities. Rather, the Sub-Committee defined several key tenants, intended to guide the future process of consultation, education and development of new incentives.

Recommendations:

1. New Fiscal Incentives:

Considerable discussion took place with regard to the current financial structure and systems within the health care framework of the Province of Manitoba. There was general feeling that the funding system for health care facilities and agencies is, in fact, a disincentive system. The creation of incentive systems to make the Manitoba's health care system even more efficient and cost-effective was a goal of the Sub-Committee.

The Sub-Committee recommended that a Task Force be established by the Minister to review and recommend a number of models which could be established to provide a more effective approach to health care funding and financial management within health care facilities and agencies in the Province of Manitoba. The members of the Sub-Committee on Administrative Impacts would be prepared to assist in the development of the structure and terms of reference of such a task force. Through a process of self-assessment, it was felt that many institutions could provide detailed recommendations for new fiscal incentives. It was felt that some existing Manitoba Health Services Commission practices should be discontinued. The Sub-Committee concluded that the concepts

of facility responsibility and accountability were contingent upon fiscal incentives. Whether budgetting of facilities continued on a global basis or line-by-line basis, the concept of level of control (provincial versus facility antonomy) requires redefinition.

2. Administrative Manpower Education:

The Sub-Committee agreed that it is extremely important that physician/managers and other health care professionals who are appointed as managers in health care facilities, acquire a sound basis of management training. It was felt that Medical Department Heads, Section Heads, Service Chiefs, etc., constitute part of the administrative fabric of health care facilities and agencies, and it is extremely important that they learn to function effectively as managers in their own right.

The Sub-Committee recommended that a health management training course be developed in Manitoba for health facility directors and other area managers. It was felt that the demand for a Health Services Management Training Course could be developed through the Faculty of Management at the University of Manitoba.

It was agreed that the faculty members who have already demonstrated expertise in programs and courses to health care managers in individual facilities, could prove to be a useful adjunct in training and manpower development. The curriculum content of such a continuing education program should be developed through consultation with the College of Physicians and Surgeons of Manitoba, the Faculty of Medicine of Manitoba, as well as health care facilities. Such a program would provide physician/ managers and other health care profession managers with a sound basis of management principles and techniques, and would take into account the impacts and ramifications of the Health Services Review Committee recommendations and other current health care management trends and practices. It was noted that the needs for a local, accessible management training program could benefit the efficient operation of health facilities throughout Manitoba. Such educational upgrading would serve the short-term needs of health facilities to improve operational objectives and administrative practices for each facility. Once a program of this nature has become established, it could serve as a model for other provinces to follow. A Made-in-Manitoba program could be marketed in other parts of the country.

3. Innovative Alternatives:

The Health Services Review Committee stressed development of innovative alternatives of treatment and prevention to the present emphasis on in-patient services. The Sub-Committee concurred, indicating that incentives were required to develop innovative alternatives for administrative practice within Manitoba.

The Sub-Committee felt that the development of innovative alternatives for administrative structures and management practices in health care facilities and agencies was a priority. There is a need to provide pro-active leadership consistent with the changing health care environment within the Province of Manitoba.

The Sub-Committee recommended that a fund be established to provide for pilot projects or demonstration models for innovative administrative structures and practices in health care facilities.

4. Administrative Evaluation:

It was very strongly felt that processes of performance appraisal and objective setting for senior health care managers was absolutely essential, given the changing health care scene. The Sub-Committee recommended that:

A) Boards of Trustees should establish definitive policies for overall governance of their respective facilities and should establish sound objectives for the overall guidance and evaluation of Chief Executive Officers.

B) Health care facilities should establish meaningful and regularized performance appraisal processes for senior health care administrators.

5. Health Information Systems:

Considerable discussion took place with regard to the need for comprehensive, timely, and accurate health information systems for health care facilities and agencies. It was generally agreed that the ability of health care facilities to analyze their own levels of operations and to undertake valid comparisons with other facilities of a like nature, required the availability of standardized and effective information. It was felt unacceptable that facilities, in this day and

age, must rely upon antiquated manual systems to provide the necessary comprehensive information that is integral to the effective management of facilities and agencies. It was noted that many manual information systems provide a burden upon staff, reducing the reliability and timeliness of the service utilization reports.

The Sub-Committee urged that Manitoba's health information be improved to provide timely, accurate and comparable data for Manitoba health facilities. Many health administrators see that their decisions have been made in the absense of useful health system data. The Sub-Committee recommended the Report currently being finalized by the Advisory Committee, Co-operative Health Information Processing Services be endorsed by the Health Services Review Committee. The statement of principles being outlined by this Advisory Committee should be ratified and submitted to the Deputy Minister without delay.

The Sub-Committee also recommended that this Advisory Committee be given the mandate to examine the selection of a medical abstract system (e.g., HMIR and PAS) as a standardized system for Manitoba health care facilities and agencies. Without the provision of such meaningful data for comparative purposes, it becomes extremely difficult, if not impossible, to undertake the types of analyses and evaluation which are so integral to today's health care management system.

6. Conjoint Planning Committee:

The need to improve and expand upon effective liaison, communication and collaboration between health care facilities, health care agencies, Manitoba Health Services Commission, community medicine, continuing care, and others was recognized as extremely important by the Sub-Committee. It was agreed that a forum must be established to improve and expand upon the communication and collaboration between these various facilities, agencies and departments. The concept of the Conjoint Planning Committee, as articulated within the report of the Sub-Committee of Continuing Care, is strongly endorsed by the Sub-Committee of Administrative Impacts.

The Administrative Impacts Sub-Committee concurred that the needs of many patients currently do not fit all health agencies' definitions. To ensure that patients' needs do not "fall between the cracks", the Sub-Committee urged that the Conjoint Planning Committee be initiated as soon as possible.

The Sub-Committee recommended that the Conjoint Planning Committee be given specific terms of reference and defined broad membership to assure effective results. This Planning Committee should assume its duties shortly.

7. Ad Hoc Health Advisory Committees:

It was agreed that there is a need to define generalized terms of reference for provincial advisory committees. It was felt that the need for such advisory committees has been recognized but that definitive frames of reference and determination of objectives, and a methodology for specific reporting and the evaluation of the work of such committees must be undertaken. It was felt that the focus of the Provincial Advisory Committee representation provides adequate input from the two tertiary care facilities and the University's Faculty of Medicine, but does not elicit the same degree of input from community hospital, other health care facilities and agencies, and because of that there are gaps and omissions in the overall planning framework and the definition of required resources, as articulated by the Provincial Advisory Committees.

The Sub-Committee recommended that the Manitoba Health Services Commission, in conjunction with health care facilities, Manitoba Health Organizations, College of Physicians and Surgeons of Manitoba and other appropriate bodies, establish a framework for the structure, terms of reference and evaluative criteria for provincial advisory committees. The need for regularized reports from these advisory committees is also greatly encouraged, as is the definition of their administrative reportability and accountability and their specific interface with health care facilities and agencies. It was also noted that the provincial advisory committees should respect the corporate autonomy and integrity of all participating facilities, agencies and health care professionals involved.

The Sub-Committee felt that membership for provincial advisory committees (e.g., Cardiac Advisory Committee and Ultrasound Advisory Committee) include representation for other service areas (e.g. community hospitals) when impacted. The committee concluded that improved terms of reference for health advisory committees may assist the tasks such as defining provincial programs as opposed to episodic and crisis orientated ad hoc reviews.

8. Administrative Change Process:

The Sub-Committee recognized the necessity for the establishment of an appropriate forum for explaining and clarifying the Report of the Health Services Review Committee and the impacts of the Report to the health care administrators and trustees of the Province of Manitoba. The Sub-Committee recommended that the Mantioba Health Organizations is well suited to act as an appropriate forum for such discussion and dialogue.

The Sub-Committee recommended that a series of regional meetings, sponsored by the Manitoba Health Organizations, be undertaken to share findings of the Health Services Review Committee to health providers and to solicit comment for administrative innovations appropriate to individual facilities. The Sub-Committee concluded that it would be inappropriate to provide a prescription of administrative changes which would infringe upon local board autonomy of individual health facilities. The Sub-Committee concluded that the recommended regional meeting forum sponsored by the Manitoba Health Organizations could reduce "the two solitudes" between administrative decisions and clinical decisions. It was felt that health care facilities be encouraged to foster administrative/medical staff directions, with regard to the administrative requirements necessary for the effective functioning of such facilities.

It was recommended that the Chairman of the Health Services Review Committee meet with the Executive Director of the Manitoba Health Organizations to develop appropriate means for the dissemination of the Report of the Health Services Review Committee and opportunities for discussions with health administrators. It is further recommended that the Manitoba Health Organizations Regional meetings be broadened in their scope to allow the participation, not only of health care administrators and trustees, but also of physicians and other health care professionals, so that the discussion, with regard to the Health Services Review Committee Report, can be maximized throughout the Province of Manitoba.

The proposed meeting forum provides for Manitoba Health Organizations regional meetings during the Fall, 1986 which could provide for trustee emphasis or provide for regional (monthly) administrators' meetings. It was agreed that either meeting forum would provide a necessary follow-up to the Report of the Health Services Review Committee and allow the opportunity for definition of innovative alternatives

appropriate to individual facilities. Such discussion could also reduce the perception that the Report of the Health Services Review Committee had little bearing upon rural health services. The proposed discussion forum would allow an opportunity for discussion of the implementation plan for altered health services in Manitoba. The Sub-Committee felt that it would be important to publicize both the findings of the Health Services Review Committee and the implementation plan for change. The Sub-Committee also felt that the Health Services Advisory Committee (after September, 1986) should serve a monitoring role to ensure that the timelines for implementation of change are followed. The Sub-Committee cautioned that justifiable public cynicism could rise if change was not perceived to occur.

The Sub-Committee strongly supported the Report of the Health Services Review Committee. It is felt that the Report provides a practical working blueprint for the future development of health care within the Province of Manitoba. The Sub-Committee is concerned that the Report and its many recommendations not be shelved, as often happens with reports and task force reports of this nature. The Sub-Committee therefore recommended that the Health Services Review Committee be encouraged to establish a pragmatic implementation plan to include time sequences and practical approaches to the implementation of approved recommendations of the Committee and its 14 other Sub-Committees.

9. Health Services Advisory Committee:

The Sub-Committee recommended that future work of the Health Services Review Committee continue on the basis of personal expertise of the membership rather than as constituents of visible organizational interests from the health care field. The Sub-Committee urged that the change process begin and cautioned that such constituency divisions may impede the process of change.

10. Review of Other Sub-Committees Recommendations:

The Administrative Impact Sub-Committee supported many of the other sub-committee reports (see Appendix for specific comments) which appeared in concert with the emphasis of the Health Services Review Committee. Three themes from the recommendations emerged during the Sub-Committee's discussions including the following:

a) Mechanisms for reduction of waiting time for diagnostic services should be introduced to reduce demands on in-patient facilities.

b) Rural regional centres should be promoted where possible and encouragement of itinerant rural diagnostic services should be promoted.

c) A future discussion forum (provided by the Manitoba Health Organizations) should be established to include the participation of many health providers and government in the process of change for health services in Manitoba.

See the Appendix for specific comments from the Administrative Impacts Sub-Committee about other sub-committees' recommendations which had administrative implications.

J. T. Litvack
Administrative Impacts
Sub-Committee, Chairman

Attachment

ADMINISTRATIVE IMPACTS SUB-COMMITTEE APPENDIX

Responses to other committees' recommendations

The Administrative Sub-Committee was tasked to review and assess the administrative impacts of the approved recommendations of 14 other sub-committee reports to the Health Services Review Committee. The contents of this appendix include each recommendation as listed in Volume II (noting the page reference) of the Report of the Health Services Review Committee. A brief comment from the Administrative Impacts Sub-Committee follows each recommendation. Such comments were provided on the basis of consistency with the themes of the Health Services Review Committee and the feasibility for implementation of each recommendation.

The recommendation of the sub-committees were as follows:

Page 61:
"The Continuing Care Sub-Committee recommended that rather than modifying (increasing) cost limits and service limits, alternative approaches be developed to respond to clients requiring service/care of a level greater than that provided by home care and of a level less than that existing in institutions (e.g. group living and special care arrangements).

COMMENT:
The Administrative Impacts Committee noted that economies of scale could not be achieved for high intensity (i.e. 24-hour care) for in-home service. The Sub-Committee urged that excessive demands on hospital beds be avoided by provision of less intensive institutional beds. The distinction between intensive home care and minimum institutional needs could be defined through future discussion of the Health Services Review Committee Report in the Manitoba Health Organizations forum.

Page 61:
"The Sub-Committee on Services for the Elderly recommended that for the high-risk elderly who wish to retain their independence, there should be a specialized forum of housing where programs, meals, and personal assistance are available on a 24-hour basis. Such accommodation should include wheel chair accessible and adapted units, and could utilize shared staff where there is juxtaposition or proximity to another facility, e.g., a personal care home."

COMMENT:
The Administrative Impacts Sub-Committee supported this recommendation.

Page 65:
"The Oncology Sub-Committee recommended that the Surgical Oncology section at the Manitoba Cancer Treatment and Research Foundation and affiliated units be expanded."

COMMENT:
The Administrative Impacts Sub-Committee concluded that the provision of dedicated beds for oncology was dependent upon a medical decision to provide quality of care. If such beds were reallocated from the existing bed supply, the Administrative Impacts Sub-Committee concurred with the recommendation. It was noted that this topic is currently being addressed by both teaching hospitals.

Page 65:
"The Terminally Ill Sub-Committee recommended that a hospice for stable terminally ill patients be established for those who do not have a home in which to be cared for."

COMMENT:
The Administrative Impacts Sub-Committee concluded that this topic required further interdisciplinary study. With varied opinions on the role of palliative care, there was no consensus to promote the concept of hospice.

Page 70:
"The Out-Patient Sub-Committee recommended that existing out-patient departments in Manitoba's major teaching hospitals should be developed and expanded as model ambulatory care facilities."

COMMENT:
The Administrative Impacts Sub-Committee supported this recommendation but urged that the model ambulatory care facilities include community hospitals.

Page 70:
"The Out-Patient Sub-Committee recommended that as model ambulatory care facilities, out-patient departments in the teaching hospitals should be used to develop and implement new types of out-patient services."

COMMENT:
The Administrative Impacts Sub-Committee supported this recommendation, expanding the concept of model ambulatory care facilities to include community hospitals.

Page 74:
"The Sub-Committee on Services for the Elderly recommended that respite care resources should be expanded throughout the province. Expansion will accommodate more scheduling and more immediate access."

COMMENT:
The Administrative Impacts Sub-Committee endorsed the concept of respite care as defined.

Page 77:
"The Continuing Care Sub-Committee recommended that discharge planning start on admission to hospital or as soon thereafter as possible. If continuing clinical instability makes such early planning for specific individuals impossible, these persons may need to occupy an acute bed until they can be appropriately accommodated in the community."

COMMENT:
The Administrative Impacts Sub-Committee concurred with the intent of the above recommendation. However, the Committee noted that the effectiveness of a hospital admission and discharge committee was dependent upon the availability of options in the community. The Sub-Committee felt that changes were required in the support system provided by the Continuing Care Office. It was noted that it is frequently difficult to distinquish between "social" and "clinical" patient instability.

Page 78:
"The Continuing Care Sub-Committee recommended that the Manitoba Health Services Commission and the office of Continuing Care develop a written admission information guide to be distributed in orienting physicians and other hospital personnel in responding to care issues of patients and families which arise at admission."

COMMENT:
The Administrative Impacts Sub-Committee supported this recommendation based upon a factual guide of existing services (as opposed to a listing of intended services).

Page 80:
"The Emergency Health Care Sub-Committee recommended that each hospital should have an active bed utilization committee responsible for admission and discharge planning."

COMMENT:
The Administrative Impacts Sub-Committee concurred with this recommendation.

Page 80:
"The Obstetric Sub-Committee recommended that hospital or departmental admission and discharge committees should actively monitor the indications for admission to acute care beds as well as length of stay, and should implement admission and discharge policies with cross-institutionalized comparisons. This activity should be the responsibility of the medical staff association at each hospital."

COMMENT:
The Administrative Impact Sub-Committee agreed with the concept of timely and accurate collection. However, the Sub-Committee noted that each hospital would be required to develop its own improved procedures. The Sub-Committee urged that a uniform method of reporting be developed among all hospitals. The Sub-Committee also noted that the issue of information reporting extended beyond the field of obstetrics to include all forms of hospital utilization.

Page 85:
"The Gastrointestinal Diseases Sub-Committee recommended that the government should investigate the value of developing many regions where concentration of new sophisticated diagnostic and therapeutic modalities should improve health care while preventing costly duplication of facilities."

COMMENT:
The Administrative Impacts Sub-Committee supported the concept of regionalized services, dependent upon adequate service volumes. It was noted that recruitment of skilled staffing is the key to allow effective regionalized services to develop.

Page 85:
"The Gastrointestinal Diseases Sub-Committee recommended that regionalization of more sophisticated radiology and skilled fibreoptic endoscopists are necessary to improve the efficiency of making the diagnosis of these diseases."

COMMENT:
The Administrative Impacts Sub-Committee supported this recommendation, noting the need for sufficient skilled manpower in regional centers. The Sub-Committee noted that an itinerant diagnostic team could travel in rural Manitoba to serve a useful consultation function.

Page 95:
"The Continuing Care Sub-Committee recommended that as a hospital approaches a maximum number of in-transit patients, it can be assured that the Continuing Care Program will continue to give high priority attention to transferring a person to a nursing home as quickly as possible, to the extent that the number of personal care home vacancies are a match with patient needs."

COMMENTS:
The Administrative Impacts Sub-Committee supported the above recommendation but noted that the Continuing Care Porgram requires expansion to have the ability to react properly to existing demands. The Sub-Committee noted a continuing need for dialogue between government and health facilities on this topic.

Page 96:
"The Continuing Care Sub-Committee recommended that to maximize service limits, a system be developed for responding to a breakdown in the provision of care at home, through emergency access to hospital."

COMMENT:
The Administrative Impacts Sub-Committee observed that the Continuing Care Program should alter its practices for using hospitals as a repository for care in a home setting or in personal care homes. The Committee noted that the above recommendation appears contrary to the general theme of the Health Services Review Committee (separate from the concept of respite beds).

Page 96:
"The Sub-Committee on Services for the Elderly recommended that considering the legitimate health needs of an aging society and their utilization of hospital services, it is recommended that all hospitals develop specific strategies to improve their own clinical resources for elderly patients and include mechanisms for linkage with appropriate community resources."

COMMENT:
The Sub-Committee on Administrative Impacts concurred with the above recommendation.

Page 96:
"The Sub-Committee on Services for the Elderly recommended that a protocol should be developed for the transfer of social crises admissions from hospitals to more appropriate locations, e.g., personal care homes or residential care facilities."

COMMENT:
The Sub-Committee on Administrative Impacts concurred with the intent of the above recommendation, noting that a distinction for "emergency" respite beds needs to be developed between hospitals and personal care homes. It was observed that no common definition of "emergency or respite" exists between health facilities or the Continuing Care Program.

Page 97:
"The Oncology Sub-Committee recommended that Manitoba Cancer Treatment and Research Foundation maintain an interest in the screening for other malignancies should cost effective procedures become available."

COMMENT:
The Administrative Impacts Sub-Committee concurred with the above recommendation.

Page 97:
"The Out-Patient Sub-Committee recommeded that the patient departments insure an effective and efficient coordination of patient care services within the out-patient clinics."

COMMENT:
The Administrative Impacts Sub-Committee concurred with the above recommendation.

Page 97:
"The Out-Patient Sub-Committee recommended that to promote greater efficiency and more effective use of resources, out-patient departments should be established as a separate administrative division or section within the parent hospitals. The single administrative structure must include direct involvement from the health care professionals working in the area."

COMMENT:
The Administrative Impacts Sub-Committee suggested that a prescriptive solution for all hospitals should be avoided. The Sub-Committee noted the concept of effective use of out-patient services should be supported.

Page 98:
"The Sub-Committee on Services for The Elderly recommended that the Manitoba Health Services Commission and the Office of Continuing Care continue their joint planning to ensure that hospital facility backup is available to support heavier care in the community. Both hospital and Community Care Programs must recognize their mutual resource dependency. However, joint planning is ineffective unless the funding parameters support this planning."

COMMENT:
The Administrative Impacts Sub-Committee supported this recommendation with the qualification that joint planning should involve hospitals as well.

Page 101:
"The Respiratory Disorders Sub-Committee recommended that global budget practices for hospitals should be changed to provide incentives for hospital funding analogous to the diagnostic related grouping utilized in the United States hospitals."

COMMENT:
The Administrative Impact Sub-Committee concurred with the concept that budgeting practices should provide incentives for hospitals. However, the Sub-Committee did not support the introduction of diagnostic related grouping as utilized in the United States.

Page 104:
The Obstetric Sub-Committee recommended that concerning patient education for high-risk antepartum patients who are to be followed in the home or hostel environment, provision must be made for detailed patient education in the most efficient fashion, perhaps with the assistance of nurse educators and a comprehensive series of video tapes."

COMMENT:
The Administrative Impact Sub-Committee agreed with the above recommendation, noting that hospitals should be supportive of patient education as finances permit.

Page 106:
"The Continuing Care Sub-Committee recommended that the issue of emergency hospital use and triage at home be referred to the Conjoint Planning Committee to assess the size of the target group and identify those already on home care, and determine whether the Continuing Care Program should be provided with resources to make intake, nursing and homemaking services available on a 24-hour-a-day basis to respond to referrals from hospital emergency wards."

COMMENT:
The Administrative Impacts Sub-Committee concurred with the above recommendation.

Page 107:
"The Not-For-Admission Surgery Sub-Committee recommended that a formal study of booking procedures, comparing block booking with other methods in Winnipeg hospitals should be undertaken."

COMMENT:
The Administrative Impacts Sub-Committee concurred with the above recommendation.

Page 108:
The Out-Patient Sub-Committee recommended that Manitoba Health should make a comparison of costs accrued to the provincial health care budget by alternative types of health service delivery and recommend the most cost effective combination."

COMMENT:
The Administrative Impacts Sub-Committee defined this item as a future task for the Health Services Advisory Committee. No further comment would be provided.

Page 110:
"The Sub-Committee on Services for the Elderly recommended that personal care home admission criteria and the panel process must be examined regularly, and audit procedures should be developed and instituted."

COMMENT:
The Administrative Impacts Sub-Committee concurred with the review of admission criteria and audit procedures.

Page 116:
"The Sub-Committee on Services for the Elderly recommended that all proposals for new programs must include a plan which evaluates the impact of the program on the patient and on the health care system. A plan for the evaluation of existing programs should be developed by all major funding and service institutions. Funding for program evaluation must be recognized as integral to funding of programs by the Manitoba Health Services Commission."

COMMENT:
The Administrative Impacts Sub-Committee supported the concepts of program evaluation. Several members expressed concern if evaluation was not routinely considered.

APPENDIX D

ADMINISTRATIVE IMPACTS SUB-COMMITTEE

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APPENDIX E

MANITOBA

MINISTER OF HEALTH
MINISTRE DE LA SANTÉ

WINNIPEG, MANITOBA
R3C 3R8

JUN 14 1984

Dear

Recently, I requested several organizations[1] to participate in a review of Manitoba's health services. Representatives have been selected for this Health Services Review Committee to consider immediate issues such as cost constraint and future issues such as structures for health service delivery. The Health Services Review Committee intends to use the services of several sub-committees to investigate particular topics which require analysis and review. I appreciate your interest to participate as a sub-committee chairman.

The deliberations of the sub-committees are to take into account:

a) the maintenance of efficacious health care;

b) the acceptance of prudent fiscal restraint; and,

c) the projected increased demand for health services brought about by the anticipated increase in the number of elderly.

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1 Manitoba Medical Association; Misericordia General Hospital; College of Physicians and Surgeons; Rural Hospital (Portage); Health Sciences Centre; Social and Preventive Medicine; University of Manitoba; St. Boniface General Hospital; Manitoba Association of Registered Nurses.

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Alternatives to be considered include a shift in focus from inpatient treatment to treatment on a day patient basis. This mode of treatment assumes an appropriate level of home health services to provide adequate support and/or alternative care in the patient's home. Also to be considered are current patterns of utilization of inpatient beds and the allocation of the required number of inpatient beds. Consideration will be given to the designation of certain specialty programs as provincial health care programs, with the appropriate allocation of resources to meet demonstrated patient needs. This overall review will include patient utilization in both urban and rural areas.

Given this context, I suggest that each sub-committee undertake its review within its terms of reference while taking into account the province's fiscal constraints. While government may be able to consider alternative types of services, the previous pattern of extensive service expansion will not likely re-occur in the foreseeable future. Rather than impose unilateral resource allocation, we have chosen to consult with key experts in the industry.

To focus the activities of all sub-committees, I provide the following terms of reference that are consistent with the Health Services Review Committee's mandate:

1) Each sub-committee will be requested to identify current and new categories of disease/treatment for which there is no alternative to hospitalization. Anticipating trends for the next decade for such categories may be based upon local experience and literature.

2) Each sub-committee will be requested to identify current and future categories of disease/treatment for which there are alternatives to traditional hospitalization. Recommendations for means to achieve the goal of increased out-of-hospital diagnosis/treatment will be welcomed. For each proposed change, the sub-committee will be requested to estimate the impact upon the quality of health care available in the future.

3) Although time is short, I would hope that sub-committees will be in a position to report to the Health Services Review Committee by September 30, 1984.

While the Health Services Review Committee may have suggested the names of some members for your sub-committee, please feel free to suggest additional membership that you feel appropriate (e.g. rural,

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physician, nursing, and other allied specialist representation). To elicit the cooperation and coordination necessary to bring together the variety of health care professionals you will have in support of the work of your sub-committee, please send your list of proposed sub-committee members to David Pascoe, Chairman of the Health Services Review Committee, 308 - 294 Portage Avenue, Winnipeg, Manitoba, R3C 0B9. Mr. Pascoe will confirm the membership of the sub-committee with the Health Services Review Committee. At least one member of the Health Services Review Committee will participate on each sub-committee to provide continuity. Professional support services to sub-committees will be provided (e.g.-minutes and data collection) by staff members of the Manitoba Health Services Commission or the Department of Health.

To begin the process, I will convene a seminar on June 19, 1984, 9:00 a.m. - 12:00 p.m., for all sub-committee chairmen to consider economic, population, and service delivery variables. Each sub-committee will be provided with information to serve its needs. Enclosed is an agenda for this seminar.

I thank you for your interest in participating in this important review process. The task before us is challenging and I am certain that the benefits that will accrue to Manitobans and the health care industry will be most rewarding. I look forward to the results of the review process.

Yours sincerely,

ORIGINAL SIGNED BY
L. L. DESJARDINS

L. L. Desjardins

Enclosure